State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.3 Table of Contents

1.4 Overview of the State

Mississippi is a predominately rural state with approximately three-quarters of the 2.6 million state residents living in non-metropolitan areas. On the south, it borders Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties occupy 47,715 square miles. The racial composition of Mississippi residents is mixed, with three-fifths of the residents white and about two-fifths black. Mississippi has the largest proportion (nearly 40 percent) of black residents among all the states. The Hispanic and non-citizen immigrant populations are small but growing, as Cubans and Central Americans have been brought in to work for the poultry, forestry, and construction industries in the state. Mississippi is, and has been for many years, one of the poorest states in the nation. About one-quarter of the population (17.1 percent) was below the federal poverty level (FPL) in 1998. According to 1998 data from the Census Bureau, child poverty has dropped below 20 percent for the first time since 1980. According to 1998 Census data, approximately 18.9 percent of Mississippi's children under 18 live in poverty. These rates are about 69 percent higher than the national average. A substantial share of employment is agricultural work. Mississippi's per capita income in 1998 was 28 percent below the national average. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state.

On the positive side, Mississippi has had a vigorous economic boom for several years. The state's per capita income grew 19 percent between 1994 and 1998, almost level with the national growth rate of 20 percent. One factor in the state's stable economic environment has been the construction of casinos, which has helped revitalize some areas of the state. Mississippi has also been able to attract other businesses, helped by the low cost of living and other favorable business conditions.

The state treasury has also fared very well. In addition to revenue growth as a result of general economic development, legalized gambling has brought in additional tax revenues. Reflecting its strong fiscal position, Mississippi had a rainy day fund of about $236 million as of 1999.

While the economic outlook for Mississippi has become more positive in recent years, the state remains one of the poorest in the nation. The state has a high poverty rate of 23 percent, and one out of every three children in Mississippi lives in poverty. A greater percentage of children than in the nation as a whole are born out of wedlock (nearly half the children born in 1998) and live in one-parent families. According to the 1998 Kids Count Data Book, Mississippi ranks 50th of the 50 states at 58 births per 1,000 females ages 15-17.

The 1999 immunization rate for two-year old children is one of the highest among the states at 87.1 percent, and is continually improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. According to the 1998 Kids Count Data Book, Mississippi had one of the highest percentages of low birth-weight babies in 1998, the highest infant mortality and child death rates; and the highest rate of teen deaths by accidents, homicide, and suicide of all 50

states. According to the same data source, Mississippi ranks 13th of the 50 states regarding juvenile violent crime arrests at 279 arrests per 100,000 youths ages 10-17. Overall, Mississippi was ranked second to last among the states in a composite rating of 10 selected measures of child well-being.

However, because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget, with the federal government providing nearly three dollars for every two dollars of state funds for overall expenditures in 1996. Nevertheless, the current rapid economic growth signals that conditions are improving, and the state has fiscal resources that could be used to further improve the situation.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Department of Economic and Community Development (DECD), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure.

These economic factors have influenced the Title V delivery system. In addition, the MSDH has begun to realize the impact of Medicaid's mandatory managed care program (HealthMACS) through a reduction of patients seen in the health department system. Also, welfare reform is being felt by a reduction in the overall number of Medicaid eligible recipients in the State.

The State Legislature created a Child Health Insurance Task Force in 1998 to develop a State Plan for the implementation of a Child Health Insurance Program (CHIP), which began providing coverage in late 1998 to children between 15 through 18 years of age between 33percent and 100percent of the federal poverty level (Phase I). A state plan to further extend coverage to all children between 100percent and 200percent of the federal poverty level was approved by the Health Care Financing Authority (HCFA) in February 1999. The implementation of Phase II began in January, 2000. This new coverage for children will continue the evolution of child health services for the next few years.

In addition, Medicaid has created a mandated managed care exemption for Children with

Special Health Care Needs (CSHCN) which sets the stage for the CSHCN program to be the primary case manager for the future of the special needs population, and should continue with the development of the new CHIP program.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

The MSDH is the state agency responsible for administering the Maternal and Child Health (MCH) Block Grant. MCH Block Grant funds are allocated in the central office to the Bureau of Women's Health and the Bureau of Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for CSHCN, is located organizationally in the Bureau of Child and Adolescent Health. All are located organizationally within the Office of Personal Health Services (OPHS), one of five offices covering the programmatic and oversight areas within the health department (see organization chart in 5.3 Other Supporting Documents). These two OPHS bureaus provide services for the three major populations targeted by the MCH Block Grant: pregnant women and infants, children and adolescents, and children with special health care needs. The office is also responsible for administering the statewide family planning program, Breast and Cervical Cancer Early Detection Program, Domestic Violence/Rape Crisis Prevention Program, Fetal and Infant Mortality review Project (FIMR), Sudden Infant Death Project (SIDS), and the Women, Infants and Children Supplemental Food program (WIC).

1.5.1.1 Organizational Structure

A number of state laws guide Mississippi's public health system and provide authorization for certain programs and policies. The OPHS is one of the five offices within the MSDH, and is responsible for all Maternal and Child Health (MCH) functions. The OPHS administers programs that provide services to the Maternal and Child Health/CSHCN population. Each Bureau within the OPHS, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and specialty clinics (see organization chart in 5.3 Other Supporting Documents**)**.

State Board of Health Authority. Section 41-3-15 Mississippi Code of 1972, Annotated, provides: The State Board of Health shall have the authority, in its discretion, to establish programs to promote the public health, to be administered by the State Department of Health. Specifically, such programs may include, but shall not be limited to, programs in the following areas:
(i) Maternal and child health;

(iii) Pediatric services;
(iv) Services to crippled and disabled children

Infant Mortality. The Mississippi Code, Annotated, Section 41-89-1 through 41-89-5 provides for the creation of the Infant Mortality Task Force and funding of the task force through the MSDH. It also provides for the powers and duties of the task force and related purposes.

Agreements with Other Agencies. Entities that serve MCH patients through contractual or cooperative agreements with the MSDH include the Mississippi Division of Medicaid and the University of Mississippi Medical Center. Sections 43-13-103, 43-13-113, 43-13-121, and 43-13-122, Mississippi Code of 1972, Annotated, provides for the receipt and use of federal funds by the Mississippi Division of Medicaid. Section 43-13-11, Mississippi Code of 1972, Annotated, states that every state health agency shall not have their budget approved until the Division of Medicaid's budget is approved and the Division of Medicaid will formulate their budget to maximize utilization of federal funds. Sections 37-115-21 through 37-115-35, Mississippi Code of 1972, Annotated, provides for the establishment and operation of the University of Mississippi Medical Center (UMC). The UMC provides a number of services to the MSDH through the MCH Block Grant including Alpha-fetoprotein/HCG screening, and neonatal transportation.

Perinatal Regionalization. Section 41-81-1, Mississippi Code 41-81-3 of 1987, Annotated, provides: the MSDH is authorized to coordinate the development and the implementation of a regionalized system of perinatal services. The MSDH is authorized to enter into contracts with and provide grants to health care providers in order to implement a statewide regionalization program.

Perinatal High Risk Management. In 1988 an act to amend section 43-13-117, Mississippi Code of 1972, was passed to authorize the Division of Medicaid to establish a perinatal high risk management program for pregnant women and infant Medicaid patients at high risk.

Newborn Screening and Follow-up. Sections 41-21-201 through 41-21-203 of the Mississippi Code of 1985, Annotated, authorize the MSDH to adopt rules and regulations to carry out the Hypothyroidism (T4) and Phenylketonuria (PKU) Newborn Screening and Follow-up Program. Sections 41-24-1 through 41-24-5 of the Mississippi Code of 1988 and 1991, Annotated, authorize the State Department of Health to adopt rules and regulations to test children to determine the presence of Galactosemia (Gal) and Hemoglobinopathies (Hgb), such as sickle cell trait and sickle cell anemia, as well as to educate the public on these disorders. Under the statutory authority, the physician attending a newborn child is held responsible for ensuring that the newborn receives the screening tests as described in these rules and regulations. State law exempts from these tests any child whose parents object thereto on the

grounds that such tests conflict with their religious practices or tenets. Under the statutory authority, screening for PKU, T4, Hgb, and Gal will be conducted statewide.

Birth Defects Registry In March 1997, Section 41-21-205 of the Mississippi Code was passed. This legislation established a birth defects registry in the State Department of Health; authorized the State Board of Health to adopt rules to govern the operation of the registry program; and authorized the department to conduct certain investigations. The law mandates the Board to specify the types of information to be provided to the birth defects registry and the persons and entities who are required to provide such information to the birth defects registry. The registry will have access to demographic data of every newborn in the state within six months of birth. The newborn screening demographic data is collected within the first few days of the child's life. The birth certificate demographic data is collected within the first six months of a child's life.

1.5.1.2 Program Capacity

The MSDH operates a statewide network of local health departments and specialty clinics which serve the MCH population. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

County level efforts are coordinated through nine public health districts which function under the specific direction of a District Health Officer (a physician), who directly supervises a District Administrator and District Chief Nurse. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator. These coordinators are also nurses who specifically provide direction and quality assurance for MCH and family planning programs throughout each district (see organization chart in 5.3 Other Supporting Documents). With programs that serve children and families located in the same office, the MSDH is able to avoid duplication of services among the various programs and maximize available human and fiscal resources. This proximity also facilitates continuity of care as the needs of the families evolve because of changes in health and personal status. When individual or family needs exceed what is available through the public health system, referrals are made to other public or private providers of health and social services. MSDH has demonstrated an ability to make progress toward achieving major health goals in spite of limited resources. Reduced infant mortality, high rates of childhood immunizations, and improved prenatal care are among the goals that have been attained through the efforts of the MSDH team across the state.

Cooperation and collaboration with other state agencies helps Mississippi maximize its resources. A study to describe current statewide regionalization efforts and their effects on infant mortality is scheduled to be completed by the end of 2000.

1.5.1.3 Other Capacity

At the state level the OPHS administers programs that provide services to the MCH/CSHCN population. Within the OPHS there are three Bureaus that serve this population. They are listed below with the Central Office FTE of each:

Bureau of WIC	43
Bureau of Women's Health	17
Bureau of Child/Adolescent Health, including CSHCN and First Step Early Intervention System (FSEIS)	53

Each bureau, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and speciality clinics. The MSDH provides childhood immunizations, well-child assessments, limited sick-child care, and tracking of infants and other high-risk children. Services are targeted to women and children whose family incomes are at or below 185 percent of the federal poverty level. The MSDH provides services to more than 120,000 children annually. Adjunct services such as the First Steps Early Intervention System (FSEIS), Genetic Screening, WIC, and the Children's Medical Program are important components of the comprehensive Child/Adolescent Health Program. Services are provided through a multi-disciplinary team approach including physicians, nurses, nutritionists, and social workers, and provides early identification of potentially crippling conditions and linkages with providers necessary for effective treatment and management. The MSDH provides services to women and infants through its family planning, maternity, and PHRM/ISS programs. In CY 1999, 97,058 clients received family planning services; of that number 30,867 were teens less than 19 years of age. During FY 1999, 13,591 women received maternity services, and a total of 9,086 women and infants received services through PHRM/ISS.

Children and adolescents are targeted for periodic health assessments and other services appropriate for their age and health status. Those services may include, but are not limited to:

(a) immunizations;
(b) genetic screening and counseling;
(c) routine and periodic diagnosis and treatment for EPSDT eligible infants and children;
(d) well-child and sick-child care;
(e) vision and hearing screening;
(f) WIC services;
(g) counseling regarding: reproductive health issues, alcohol, tobacco, and substance abuse, and sexually transmitted diseases;
(h) comprehensive developmental services to children birth to age 3;
(i) dissemination of information on the benefits of protective dental sealants to families of children receiving health department services; and,

(j) referral and case management for treatment of conditions where services are not readily available.
(k) PHRM/ISS

Services for Children with Special Health Care Needs and services for children and adolescents are direct personal health care services defined as interventions for high risk individuals, case management, care coordination, primary and preventive care, health education and counseling.

The CMP has a very strong link with the county health department system which is based in 81 counties of Mississippi. This system is utilized to provide clinic screening and referral information; in addition to providing a base of operation for central office staff when clinics are conducted at the community level.

The CMP has developed very effective lines of communication with the University of Mississippi Medical Center (UMC), the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

The CMP also maintains a major link with health care providers through the CMP Advisory Council, which includes physicians, parents, hospital representatives, anesthesiologists, physical therapists, social workers and other health care providers. Through these resources, providers are advised of the expanded effort to provide services to disabled children under sixteen (16) who receive SSI benefits under Title XVI. The Children's Medical Program has led the way to coordinate communication between CMP, Social Security, and the State Disability Determination Office.

The CMP works to develop and strengthen lines of communication between all state agencies who provide assistance to CSHCN and to the blind and disabled population under sixteen (16) years of age. This includes invitations to CMP advisory council meetings, both parent and professional, by the CMP for information purposes.

The Title V agency has installed a toll-free telephone line in cooperation with the Bureaus of WIC and Women's Health. The line provides assistance to clients seeking information about MCH services, Medicaid, WIC, and other services. This has proven to be a valuable tool for encouraging early entry into prenatal care and to further link the private and public sectors. Publicity is through a newsletter published by the

Mississippi Chapter of the American Academy of Pediatrics, printed on brochures, posters and a Teen Help Card.

Toll-free numbers in the agency which are directly related to services for the

MCH/CSHCN population include a Genetics/Early Intervention line, an HIV/AIDS line, and a CMP line.

The full-time equivalent (FTE) for local staff available to serve the MCH/CSHCN population fluctuates based on the number of contract staff being used at any given time. Staff qualifications for key OPHS staff are as follows:

BIOGRAPHICAL SKETCHES

David B. Beck, MPPA, is currently the Director of the Office of Personal Health Services. His public health career began in 1980 as District Administrator of Public Health District IV. Prior to becoming the director of OPHS, he was Director of the Bureau of Home Health. Before coming to the public health setting, he worked as a project analyst with the Golden Triangle Planning and Development District. He holds undergraduate and graduate degrees from Mississippi State University. He is also a graduate of the Southern Regional Training Program in Public Administration from the Universities of Alabama, Tennessee and Kentucky.

Donald Grillo, MD, is a Board Certified OB/GYN Physician currently serving as Medical Consultant to the Bureau of Women's Health. Dr. Grillo also served as the Director of Public Health District V, the largest public health district in the state for over 10 years. He is a retired colonel with the United States Air Force. His public health career in Mississippi began in 1981 as the consultant for the MSDH Family Planning and Maternity programs. Dr. Grillo has been very instrumental in bringing a wealth of medical knowledge and training to other physicians in the state concerning women's health issues.

Marianne E. Zotti, DrPH, RN, MCH Epidemiologist for CDC was a faculty member and administrator in the university setting for eight years prior to working for CDC. She taught several formal academic courses in undergraduate and graduate nursing and public health, served on the planning committees and as faculty for several conferences, conducted research on health outcomes and prenatal care among high risk women, and conducted community needs assessment activities. In 1999 and 2000, she served as a small group facilitator at the CityMatch Data Use Institute in Atlanta. During 1999-2000 she served on the AMCHP pre-conference Data Skills Building Planning Committee. Dr. Zotti's role consists of coordinating and training staff, analyzing, and reporting data in the MCH Needs Assessment, monitoring the quality of data, epidemiologic analysis on selected topics, surveillance, and assisting with the creation of infrastructure for data collection and management.

Daniel R. Bender, MHS, has been the Director of the Genetics Program since 1983 where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Daniel started nine satellite genetic clinics in the

state and started the first genetics database in Mississippi. He also developed the Mississippi Birth Defects registry. Daniel's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science. Daniel has made many presentations which include Health Care for the Poor, the National Neonatal Screening Symposium, and the American Public Health Association.

Hazel Gaines RN, MS has been the Director for the Bureau of Women's Health since 1995. Her duties involve oversight of a variety of women's health programs. Since 1993, she has served as faculty for the Delta regional AIDS Education and Training Center and presently serves as chair of the Program Services Committee for the March of Dimes. Hazel has many experiences in planning and conducting training conferences such as the MCH Annual Conference, Family Planning, and CSHCN, and the March of Dimes Nursing Conference on Preconceptual Care. Her public health career began in 1975 as a county public health nurse. Since that time, she has held positions as a District Home Health Supervisor, State MCH Nurse Consultant and Perinatal Division Director.

Robert M. (Mike) Gallarno MSSW, LCSW is Director of the Children's Medical Program, Mississippi's Title V CSHCN program. He has eighteen years of post-Masters experience in healthcare settings, most of which have been in child health and maternal/child health settings. Professional experience has included practice at the direct service, supervisory, and administrative levels. He has co-authored related articles published in refereed journals and made numerous presentations related to child health issues, including a session at the Tenth European Congress on Perinatal Medicine. He is chairman of the Board of Directors for the Mississippi Chapter of the March of Dimes, is a past president of the Mississippi Perinatal Association, a former Board member of the National Association of Perinatal Social Workers, and a member of the Board of Directors of the Mississippi Chapter, National Association of Social Workers.

1.5.2 State Agency Coordination

There are various organizational relationships that exist between the MSDH and other human service agencies that work to enhance the capacity of the Title V program. Examples of MSDH's coordination efforts with other human service agencies are as follows:

- **Substance abuse programs.**
  The Born Free project, which originated with the MSDH, networks available community resources for the provision of services to substance-involved pregnant

women and their infants. Other agencies involved in the Born Free network include: (a) the University of Mississippi Medical Center; (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers; (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by Catholic Charities.

- **Mental Health.**
  The MSDH county health departments make referrals to community mental health centers for families who have experienced Sudden Infant Death Syndrome (SIDS) if requested by the family. Also, the MSDH has a representative who participates on the State Developmental Disabilities Council. The First Steps Early Intervention System (FSEIS) has recently contracted with the Bureau of Mental Retardation in the DMH. Each of the five regional retardation centers submitted a proposal to expand their capacity to serve infants and toddlers and their families in natural environments, thus moving more away from the traditional facility-based service delivery model to a family-centered natural environment. These contracts expand the MSDH capacity to deliver services in some extremely rural and impoverished areas of the state.

- **First Steps Early Intervention System (FSEIS).**
  The MSDH is the designated lead agency for Part C (Early Intervention System) of the Individuals with Disabilities Education Act (IDEA). This system, as well as the Newborn Genetics Screening Program, provides a vital component for early identification of infants requiring special interventions. The FSEIS, which is structurally located within the Bureau of Child and Adolescent Health, has established an Interagency Coordinating Council which brings together the State Departments of Mental Health, Education and Human Services, universities, parents of children with special needs, providers of services, and others, to develop a comprehensive system of family-centered, community-based, culturally-competent services. Local interagency councils support the planning, development, and implementation of the system at the community level.

  The FSEIS coordinates screening, evaluation and assessments, service coordination, the development of an Individualized Family Service Plan and service delivery for children from birth to 3 years of age with developmental delays or conditions known to cause developmental delays. Appropriate state and local health, education, mental health and social service agencies are involved to provide appropriate interventions to prevent or reduce developmental delay. Children eligible for the FSEIS are identified through,
  and referred from, local health department Early and Periodic Screening,

Diagnosis and Treatment programs (EPSDT), Perinatal High Risk Management/Infant Services System (PHRM/ISS), other child health activities, the Newborn Genetics Screening Program, Children's Medical Program (CMP), other public agencies serving infants and toddlers, and the private medical community. FSEIS services are enabling and infrastructure related and provide direct service through care coordination, interventions for high risk individuals and respite care.

- **Mississippi Statewide Immunization Program.**
  The MSDH's Statewide Immunization Program is primarily funded by the Centers for Disease Control, but MCH funds are used to support some staff in local health department clinics. A statewide coalition has been established that is comprised of health care professionals (organizations and individuals), immunization providers, community-based organizations, social/civic groups, lay people, and others with an interest in improving the immunization status of Mississippi's children. This broad-based group provides the framework for promoting the implementation of the immunization monitoring and tracking system in non-health department clinics.

- **Department of Human Services (DHS).**
  DHS provides services that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemical dependent adolescents.

  DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MSDH currently receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, and a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force.

  DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75percent of the budget. The Quality Child Care Development portion of the funds provides funds for training for child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MSDH for child care facilities licensure.

- **Division of Medicaid.**
  The Division of Medicaid is a key player in the reimbursement for services to patients seen in MSDH clinics. A representative from Medicaid is currently an

active member of the State Systems Development Initiative (SSDI) Ad Hoc Committee for SSI issues. In addition to a cooperative agreement with the MSDH which allows billing for specific services provided to PHRM/ISS and other non-high risk patients, the MSDH assists Medicaid in assessing pregnant women and children for Medicaid eligibility using outstationed eligibility workers and a two-part eligibility form with 185percent of poverty as a threshold, thereby preventing untimely delay for clients who need Medicaid coverage. The MSDH State Health Officer serves on the CHIP Medical Advisory Committee.

- **Community Health Centers/Primary Health Care Association.**
  A primary care cooperative agreement with the Bureau of Primary Health Care has been administered by the MSDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the 21 community health centers (CHCs). Perinatal providers are placed in communities of greatest need through a joint decision-making process of the Mississippi Primary Health Care Association (MPHCA) and the MSDH Primary Care Development Program, making access to care available to many pregnant women and their infants. The Rural Health Program works closely with Primary Care Development to promote the recruitment and placement of providers in rural areas.

  During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MSDH for the purpose of contracting with Mississippi Qualified Health Centers (MQHC) to: increase access to preventive and primary care services by uninsured or medically indigent patients; and, to create new services or augment existing services provided to uninsured or medically indigent patients, including, but not limited to: primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

  The Mississippi Primary Health Care Association (MPHCA) is one of the twenty-four primary care associations funded the Health Resources and Services Administration (HRSA) to implement a Medicaid/CHIP Outstation Demonstration Pilot. This Medicaid Demonstration Pilot has expanded on the foundation laid by the regional and national project TEAM (The Early Access Model for Integrated Health Care). The Medicaid/CHIP Demonstration has built on this experience and these existing partnerships to include them in “Train the Trainer” sessions on the Medicaid/CHIP application process and how to complete the one-page Medicaid/CHIP application.

  The MSDH HIV/AIDS Program maintains contractual agreements with a number of community agencies. The Jackson/Hinds Community Health Center provides AIDS education and information services to their clients in Hinds County and the

Jackson public school system. Another agreement with the Aaron Henry Health Center in Clarksdale provides AIDS education and information to residents of Quitman, Tallahatchie, Tunica and Coahoma counties.

The Division of Reproductive Health maintains six contracts with community health centers and four contracts with universities and/or colleges for the provision of contraceptive supplies and educational materials. These contracts have been formulated with the Aaron Henry Health Center, Arenia Mallory Health Center, G.A. Carmichael Health Center, Northeast Mississippi Health Care, Inc., Southwest Health Agency for Rural People, Access Family Health Services, Jackson State University, Alcorn State University, Tougaloo College, and Coahoma Community College.

The Division of Immunization located in the Office of Community Health Services, provides vaccine to private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Bureau of WIC (Supplemental Food Program for Women, Infants, and Children) has a contractual relationship with 19 community health centers for the purpose of certification of women, infants, and children for provision of WIC food and/or formula through distribution centers located throughout the state.

Marion County Health Department in Public Health District VIII and the Lawrence County Health Department in Public Health District VII work cooperatively with local community health center staff, whereby community health center staff provide PHRM/ISS services to maternity patients receiving prenatal care at the county health departments.

Those community health centers that provide EPSDT services are also subject to the Division of Medicaid requirement for periodic lead screening. As the MSDH expands its statewide program of lead screening and follow-up to improve access to this service for potentially vulnerable populations, the cooperation of community health centers continues to be critical to its success in implementing community based interventions.

- **Children's Medical Program (CMP).**
  CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include staff physicians of the University of Mississippi Medical Center, the only state funded medical teaching and tertiary care facility. A representative from the MSDH also serves on the State Developmental Disabilities Council.

- **Maternal Death Review.**
  The Mississippi State Medical Association's Committee on Maternal and Child Care reviews all cases involving maternal death cases in the state. All maternal death certificates and matching birth certificates (if there was a live birth) or fetal death certificates are sent to the director of the Bureau of Women's Health. District and county health department staff are requested to gather information regarding prenatal care, labor and delivery, postpartum care and any other information surrounding the death. This information is used for both the in-house review and for the review by the Mississippi State Medical Association's Committee on Maternal and Child Care. The death certificates were revised in 1998 and a block added to check if the decedent had been pregnant within the last 90 days. The MCH Epidemiologist and the staff from the Bureau of Women's Health have reviewed the MSDH procedures for surveillance of maternal deaths, and are working together to enhance agency policy regarding this surveillance of maternal mortality, data collection materials and procedures, and the training of local Maternal/Child Health and Family Planning Coordinators.

- **Infant Mortality Task Force.**
  The MSDH provides staff to the Infant Mortality Task Force, the purpose of which is to foster the reduction of infant mortality and morbidity in Mississippi and to improve the health status of mothers and infants. The Task Force is composed of eleven (11) voting members, one ex-officio or non-voting member from DHS, MSDH, Department of Education, Division of Medicaid, the University of Mississippi Medical Center (UMMC), and the Mississippi Primary Health Care Association, plus the chairman of the Senate Public Health and Welfare Committee and one member of the said committee to be designated by the chair, and the chairman of the House Public Health and Welfare Committee and one member of the said committee to be designated by the chair.

  According to its statutory authority, the Task Force shall:
  1. Serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;
  2. Conduct studies on maternal and infant health and related issues;
  3. Recommend to the Governor and the legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; and
  4. Report annually to the Governor and the Legislature regarding the progress made toward the goals and the actions taken with regard to recommendations previously made.

- **Dietetic Education.**
  The CSHCN program nutrition staff are working with university affiliated nutrition education programs in the state to develop and implement community-

based experiences for senior or graduate nutrition/dietetic students. These experiences are designed to prepare the students to work with special needs populations and to be significant contributors to the interdisciplinary teams that assist families with their child's care.

- **Rural Health Program.**
  The MCH program works collaboratively with the Rural Health Program in resolving access to care issues. This program is administered by the MSDH Bureau of Health Resources. This program has been funded through a Federal Office of Rural Health Policy grant since August, 1991. There are four mandated functions under the grant: (1) to establish and maintain a clearinghouse of rural health issues, trends, and innovative approaches to health care delivery in rural areas; (2) to coordinate activities carried out in the state that relate to rural health care in order to avoid redundancy; (3) to identify federal and state programs for rural health and provide technical assistance to public or nonprofit entities regarding participation in the programs and; (4) an option to provide technical assistance to rural hospitals and communities on recruitment and retention of health care professionals.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures
(See Forms 4 and 5)

2.2 Annual Number of Individuals Served
(See Forms 6, 7, and 8)

2.3 State Summary Profile
(See Form 10)

2.4 Progress on Annual Performance Measures

The MCH programs are often the first point of entry into the health care system for many women and children, thus, it is essential that other community resources, private and public, be coordinated with health department services. In developing the health service system, a comprehensive, community based, culturally sensitive approach has been used to encompass both the public and private health resources, as well as linkages with social and rehabilitative services.

MCH Block Grant funds services for pregnant women and infants, children and adolescents, and children with special health care needs. A minimum of 30percent of the total grant must be spent on children and adolescents and 30percent on CSHCN,

while no more than 10percent can be spent on administration. Preventive and primary care services for infants, children and adolescents are targeted at major health problems including high infant mortality rates, teen pregnancy, and access to care. However, the delivery of these services are complicated by lack of transportation, pervasive poverty, and a shortage of health care resources for the poor. Services are provided to more than 120,000 infants and children and consist of childhood immunizations, well child assessments, sick-child care, and tracking of infants and other high risk children, targeting those with family incomes at or below 185percent of the federal poverty level. Adolescent services include counseling for the prevention of substance abuse, school dropout, suicide, high risk behaviors, and sexual activity.

Services for children with special health care needs are designed to provide medically needed services to children with congenital anomalies (cerebral palsy, cleft lip/palate, heart disease, orthopedic disorders, scoliosis, urological disorders, and others). Over 5,000 children and their families are expected to be served in Fiscal Year 2001. Program efforts, which are rehabilitative in nature, are designed to provide medical and surgical assistance to middle and low income families of these children in order to correct or reduce physical handicaps.

Direct Health Care

Pregnant Women, Mothers and Infants

SPM #4: Percent of children testing positive for genetic disorders who received appropriate treatment and follow-up. In CY 1998, approximately 73percent of the patients referred to MSDH satellite screening clinics for appropriate treatment and follow-up were referred as a result of a positive test at other clinics. Children are screened for genetic disorders and referred to seven satellite clinics strategically located in the state. The clinic staff consists of a medical geneticist, a nurse and a social worker. The clinics are held on a monthly or quarterly basis, based on need. The patients are referred to the satellite clinics by health care professionals in the private and public health care system. Genetics Coordinators in each public health district maintain an appointment tracking system and continue to provide outreach to those patients who do not keep scheduled appointments.

SPM #7: Prevalence of infants born with neural tube defects. In CY 1998, of the 42,917 live births in Mississippi, there was a prevalence of 3.0 per 10,000 newborns with neural tube defects. The MSDH Family Planning program counsels women regarding the need for daily consumption of folic acid or a multi-vitamin containing

0.4 mg of folic acid for women capable of becoming pregnant. Several MSDH MCH staff are members of the March of Dimes folic acid coalition.

In CY 1998, the Folic Acid Module in the Behavior Risk Factor Surveillance System (BRFSS) was administered. The results indicated that 41percent of women age 18-24, 36.5percent of women age 25-34 and 51.7percent of women age 35-44 said that they currently take vitamin pills or supplements. When asked if any of these were multi-vitamins, 72.5percent of females 18-24, 80.7percent of 25-34 year olds, and 78.0percent of 35-44 year olds said yes. The 18-24 year old females said 6.5percent of the vitamin or supplement contained folic acid, 13.9percent and 19.8percent of the 25-34 and 35-44 year olds, respectively, said their vitamin or supplement contains folic acid. 25.4percent of the females 18-24, 31.7percent of the 25-34year olds and 23.1percent of the 35-44 year olds said folic acid was taken to prevent birth defects. This information demonstrates the need for more public awareness related to the need for folic acid.

Preventive/Primary Care Services for Children/Adolescents

NPM #1: The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. One hundred percent of Mississippi's SSI beneficiaries less than 16 years old received rehabilitative services from the state's CSHCN program, either directly or indirectly. Through a series of meetings with the Division of Disability Determination Services (DDS) representative, it was determined that all SSI beneficiaries less than 16 receive Medicaid. Due to Medicaid regulations, all children on Medicaid are eligible for rehabilitative services. If a child on Medicaid needs a particular service not covered under Medicaid, the CMP will either cover the service if the child is eligible for CMP or will assist with the development of a plan of care for the child's physician to submit to Medicaid to achieve coverage. Therefore, all children under the age of 16 who are on SSI are provided rehabilitative services through a collaborative effort of CMP, DDS, and Medicaid.

Services for CSHCN

NPM #2: The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients. According to the MSDH Annual Report for 1998, the CMP spent $6 million on diagnostic and treatment services for 6,249 children. Services included hospitalization, physicians' services, appliances, and medications. The CMP is rehabilitative in nature, and its goal is to correct or reduce physical handicaps. The program provides hospital and surgical care in addition to braces, seating devices, and durable medical equipment as required by the patient's condition. The program also provides assistance to hemophilia, cystic fibrosis, sickle cell, and patients with genetic disorders as special program categories. Because of a strong commitment to the comprehensive needs of the state's CSHCN population, the CMP provides multi-disciplinary services including nursing, nutrition, social work,

physical and communicative therapies. Contracts with the UMC provide specific case management services for pediatric cardiology and orthopaedics and for children with cystic fibrosis. In the upcoming fiscal year, the CMP will be working toward reorganization of its program, with plans to develop three case management positions at the state level in the areas of nursing, nutrition, and social work.

The CMP has a very strong link with the county health department system which is based in 81 counties of Mississippi. This system is utilized to provide clinic screening and referral information, in addition to providing a base of operation for central office staff for clinics conducted at the community-based level.

The CMP has developed very effective lines of communication with the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

Enabling Services

Pregnant Women, Mothers and Infants

SPM #10: Access to and availability of MCH services for Spanish speaking clients. The State Systems Development Initiative (SSDI) project, an MCH set-aside, is engaged in activities focusing on the Hispanic population in the state, specifically in Scott County, Mississippi which is the entry point for many of the workers seeking employment and residency. Project activities to increase the availability of MCH services include assessing community needs and establishing a position for a part-time bilingual outreach worker, similar to the position established on the Mississippi Gulf Coast to serve the Vietnamese population there. Assessing the needs in this area is an ongoing process and is under the guidance of the Scott County Interagency Council, a group chaired by the local Community Action Agency and supported by the SSDI project. However, SSI funding ceased with the completion of the previous grant cycle. New funding has been secured through a Mississippi Department of Human Services sub-grant.

The SSDI project has identified other service providers that work collaboratively with MCH resources to enhance the availability of MCH services to Hispanic families in Scott County. With the assistance of a publisher, the project is developing a bilingual version of the “child health diary” that in its English version, is provided by the SSDI project through the Early Intervention System to every newborn in the state.

In DeSoto County (Public Health District I), an interpreter has been employed through a family planning special initiative and assigned specific days in the clinic for the purpose of interpreting available services to non-English speaking clients. Spanish

health education and teaching materials have been purchased for use with these clients, and the interpreter is also developing bilingual versions of some of the agency's family planning and prenatal health education materials. Community outreach activities are also being done with the interpreter serving as a liaison between the health department, hospitals, private providers, and school systems.

The Chickasaw County Health Department (Tombigbee Public Health District IV) has a Spanish speaking nurse practitioner once a week for the purpose of assisting the Hispanic population in accessing available services. The clinic also has a contractual agreement with an interpreter for assistance when the clinic's nurse practitioner is not available. Moreover, the Nurse Coordinator for the clinic currently serves as chairperson of the local Cultural Diversity Task Force that meets to address situations that affect this population.

The March of Dimes has sponsored two Comenzando Bien trainings for two public health districts and the community. Comenzando Bien has two program components, a cognitive component, designed to provide accurate and timely information in the area of prenatal care and pregnancy. A behavior oriented component designed to promote behavior changes in those areas that need improvement - such as seeking prenatal health care - or to support existing behaviors which promote health pregnancies.

Preventive/Primary Care Services for Children/Adolescents

Services for CSHCN

NPM #3: The percent of Children with Special Health Care Needs in the State who have a "medical/health home." In FY 1999, approximately 63.3 percent of Children With Special Health Care Needs (CSHCN) in Mississippi had a medical home. However, the Children's Medical Program (CMP) recognizes the importance of every child having an identified, accessible, community medical home. In an effort to foster this philosophy, the CMP strives to implement the following process:

- Identify primary care physicians on the CMP application and request that information be provided regarding the child's needs.

- If the child does not have a primary care physician (PCP), contact the child's family to discuss the need for a PCP and assist with the identification of a local physician and referral sources.

- Provide copies of all CMP progress notes to the designated PCP.

- Identify the PCP on the patient record and verify on each clinic visit or encounter.

- Strongly encourage children who appear to be eligible for Medicaid or other funding sources to apply to establish a payment source for primary and community care.

- Assist the PCP by providing case management, which includes coordinating clinic appointments, scheduling studies, assisting with referrals for service, recommending technology assistive devices, and technical support to the PCP and staff as requested.

- Work with the state chapter of the Academy of Pediatrics (AAP) in promoting national AAP policy on Medical Home Programs for children with special needs.

The CMP is designed to provide medical and surgical assistance to middle and low income families of CSHCN. Blake Clinic, the CMP central clinic in Jackson, provides services to children from all nine public health districts. CMP provides specialty clinics in 19 sites throughout the state to facilitate the provision of community-based services. The specialty clinics are staffed by physicians from the local community wherever possible, through contractual agreement with the CMP . Ideally, this assures continuous access for episodic care and routine preventive care. However, when no local physicians are available, or willing, to care for the unique needs of these children, the CMP contracts with physicians in private practice from the Jackson metropolitan area and through the University of Mississippi's Medical Center departments of Orthopedics, Cardiology, Pediatrics, Genetics, and Neurology to staff those clinics. Support for these clinics is provided by local social work and nursing staff who know the local community and understand the cultural uniqueness of that community. In addition to clinical services, the CMP utilizes the MSDH pharmacy to provide drug therapy throughout the state. This service is provided to several diagnostic groups regardless of family income on a fee-for-service basis.

The CSHCN Program has maintained ongoing communication with the state Medicaid agency to expand services for children with special needs and to ensure that eligible children receive the maximum level of service available. The CMP also maintains dialogue with the State Disability Determination Services unit and the Social Security Administration to help ensure a maximum level of services for all eligible children through these agencies.

Population Based Services

Pregnant Women, Mothers and Infants

NPM #9: Percent of mothers who breastfeed their infants at hospital discharge. According to the 1998 Ross Mothers Survey, 41.7 percent of mothers in Mississippi breastfeed their infants at hospital discharge, up from 38.3percent in 1997. 13.0percent of these mothers continue to breastfeed at 6 months, up from11.1percent in 1997. Of the WIC population, 32.5 percent of mothers breastfeed their infants at hospital discharge, up from 29.3percent in 1997, and 7.0 percent are breastfeeding at 6 months, up from 6.8 percent in 1997.

SPM #8: The percent of deaths to infants age 0-12 months caused by motor vehicle crashes due to infants not being properly restrained in safety seats. In 1998, the percent of deaths to infants age 0-12 months caused by motor vehicle crashes (N = 4) due to infants not being properly restrained was 50 percent.

NPM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge. In FY 1998, 94 percent of all babies born in Mississippi hospitals are screened for hearing impairments prior to discharge from the facility. All hospitals who deliver 100 or more babies per year are providing universal screening on site. Approximately 200 babies are born either in hospitals that do not provide screening or in a non-hospital setting. The Mississippi State Legislature has mandated universal hearing screening for all newborns.

NPM #4: Percent of newborns in the state with at least one screening for each of PKU, Hypothyroidism, Galactosemia, Hemoglobinopathies. In FY 1999, approximately 99.8percent of all newborns in the state receive at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies. The Newborn Genetic Screening and Evaluation Program provides for screening of all births occurring in the state for PKU, T-4, Hemoglobinopathies and Galactosemia, and follow-up on all positives for diagnosis and treatment. A prophylaxis program is available for infants born with hemoglobinopathies.

Genetics Clinics have been established around the state in seven public health districts to provide evaluations and counseling for families of infants who test positive during the newborn screenings. The clinics also assist in coordinating the care of the infants with local health departments and private physicians where applicable. Services under this program are population based prevention and direct personal health care by category of case management, care coordination, and primary care.

Preventive/Primary Care Services for Children/Adolescents

NPM #5; Percent of children through age 2 who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus

influenza, hepatitis B. According to the 1999 immunization survey of children at 27 months of age, 87.1 percent have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B. In 1998, the immunization rate for this age group was 84.2 percent. This survey is conducted annually to obtain statistical estimates of immunization rates of two-year-old children in Mississippi.

The results of the 1999 survey of two-year-old children suggests that the State of Mississippi is moving gradually toward achieving the 90 percent national goal set for the year 2000. The MSDH will continue to emphasize the significance of completing immunizations by two years of age. Also, professional and public education will continue to be a part of the state effort to increase immunization awareness.

SPM #1 : Percent of Medicaid eligible children who receive oral health education. Currently, approximately 25 percent of Medicaid eligible children receive oral health education. The Dental Health Program is working with local dental organizations, Head Start centers, Medicaid, and school systems to develop and monitor these data.

NPM #6 : The birth rate (per 1,000) for teenagers aged 15 through 17 years. The 1998 birth rate (per 1,000) for teenagers age 15 through 17 years is 47.2 per 1,000 live births. These data indicate that the teen birth rate has declined slightly but steadily for four years, although the rates remain high, especially in certain populations.

Trends in Mississippi are similar to those seen nationally. In Mississippi, 20.0 percent of all babies born during 1998 were born to teenagers, which represents a one percent decrease from 1997 (21percent). More than 24.4 percent of those mothers were giving birth to their second, third, fourth, or fifth child. In addition, approximately 81.2 percent of the teen mothers were unmarried. Approximately 40.0 percent of the teen mothers were 17 years old or younger.

SPM #2: Adolescents' use of tobacco products. According to the 1998/99 Youth Risk Behavior Survey (YRBS), 32.5percent of Mississippi's adolescents in grades ninth through twelfth use tobacco products. After a December 29, 1997 Court Order approving the Mississippi Tobacco Pilot Program and the receipt of pilot program monies from the tobacco companies, the Attorney General held meetings with representatives from medical associations, education groups, youth organizations, and law enforcement organizations, as well as private and business groups to discuss strategies for addressing tobacco use among children in Mississippi. As a result, the Partnership for a Healthy Mississippi (the Partnership), with representatives from the private and public sectors of the State, was formed. The mission of the Partnership is to create a youth-centered, statewide collaboration, dedicated to creating a healthier Mississippi and eliminating tobacco use among Mississippi's youth.

SPM #9: The rate of repeat births (per 1,000) for teenagers less than 19 years old. The rate of repeat births per 1,000 for teenagers less than 19 years old for CY 1998 in Mississippi was 22.3 percent. The MSDH has expanded efforts to reduce this rate by conducting collaborative training with adolescent pregnancy prevention organizations, agencies, and support groups established throughout the state for the purpose of combating teen pregnancy, as well as working with local health department staff to enhance family planning services to adolescents, thus making the prevention of repeat pregnancy a priority in care plans for teen clients.

NPM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. It is estimated that 8percent of all Medicaid-eligible third grade children in Mississippi have received protective sealants on permanent molar teeth. The MSDH began negotiation with the UMC School of Dentistry to determine baseline data during the current grant year.

SPM #3: Percent of children #6 years of age with reported lead levels above 10 mcg/dl identified for intervention. Of the 6,931 children ≤6 years of age screened by the MSDH in CY 1998, 748 (10.7percent) had a venous lead level ≥ 10 mcg/dl. Private providers reported 278 children with a venous lead level ≥ 10 mcg/dl in CY 1998 (denominator unreported). Children six months through six years of age are screened by the MSDH based on Medicaid status and/or answers to a lead risk assessment screening tool. Any venous level $10 mcg/dl is considered elevated and is referred to a clinician for evaluation. A venous level between 15-19 mcg/dl is screened by a social worker, nurse or other qualified individual for an environmental investigation (education) and a home visit, if indicated. The MSDH has recently negotiated with Medicaid for reimbursement for home visits done by a public health nurse related to elevated lead levels. These home visits will include general lead poisoning education, education on the importance of good nutrition, the need for continued blood lead testing, general health status assessment, identification of other children in the home in need of screening, and a very general home assessment (pica habits, age of home, occupational exposures, play habits, etc.).

NPM #8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. In Mississippi in 1998, the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) is 11.2. The Healthy People 2000 objective is 5.5 per 100,000 motor vehicle crashes. Injury-related deaths for Mississippi exceeds the national rates in each of the major injury categories, unintentional and intentional. Despite evidence that almost all injuries are preventable, they constitute one of the most tragic and costly public health problems to date.

In Mississippi, as well as the nation, injury is the leading cause of death for persons between the ages of one and forty-four. Unlike heart disease or cancer, injury-related deaths disproportionately strike the young, resulting in more years of potential life lost

than those two combined. Because injury is now the fourth leading cause of death in Mississippi, with a devastating impact on the cost to the health care industry, it is considered a major public health concern.

SPM #6: Development of the Department of Health's capacity to conduct birth defects surveillance: House Bill (HB) 913 authorized the establishment of the Birth Defects Registry and was signed into law by the Governor on March 26, 1997. The Registry has been established within the MSDH for the purpose of identifying and investigating birth defects, and maintaining a central registry of cases of birth defects. The Birth Defects Registry will be used for the purpose of: 1) providing information to identify risk factors and causes of birth defects; 2) providing information on other possible causes of birth defects; 3) developing strategies to prevent birth defects; 4) providing for interview studies about the causes of birth defects; and 5) collecting of birth defect information.

Services for CSHCN

Infrastructure Building Services

Pregnant Women, Mothers and Infants

NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. During CY 1998, 80.1 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents an increase from 79.7 percent in 1997.

One outreach activity utilized to get mothers to seek early prenatal care was the Health Info Line listing in telephone books around the state. Between November 1997 and April 1999, the Moms and Babies, Teen Health, and Reproductive Health menus received 25,399 message exposures.

NPM #15: Percent of very low birth weight live births. Two percent of all the births in Mississippi during 1998 were very low birthweight births. This rate remained the same as in 1997. Using regression analysis to develop projections for this NPM, current projections indicate that this percentage will not change. One program currently in place to help reduce the percent of very low birthweight births include the Perinatal High Risk Management/Infant Services System (PHRM/ISS) and the Born Free program administered by Catholic Charities.

NPM #17: The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. During 1998, 34.7 percent of very low birthweight infants were delivered at tertiary centers. At present, only two hospitals are

tertiary perinatal centers, the UMC in Jackson, and the Keesler Air Force Base Hospital on the Gulf Coast, which is available only to military personnel and their families. There are 13 hospitals designated as Level II facilities with neonatologists and another 26 as Level II without a neonatologist. Sixteen hospitals provide basic obstetrical services. When looking at the percent of very low birth weight infants delivered at Level II hospitals with neonatalogists and NICUs, the percent is much higher.

In the northern part of the state, many women deliver in Memphis, Tennessee and a few in other sections of the state deliver in New Orleans, Louisana and Mobile, Alabama. TennCare has made it more difficult for women from Mississippi to get into the University of Tennessee Medical Center if they do not have Medicaid.

Preventive/Primary Care Services for Children/Adolescent

NPM #12: Percent of children without health insurance. According to data released by The Children's Defense Fund, in the 1998 Mississippi Profile, 18.6percent of all children in Mississippi are uninsured, for a total estimated at 159,000. However, the Mississippi Child Health Insurance Program (CHIP) Commission created by the Legislature recognizes and/or references the state's estimate of 15.3percent uninsured children.

SPM #5: Infants screened and referred for hearing impairment $35 dB nHL will receive appropriate follow-up and intervention upon hospital discharge. Children with hearing loss equal to or greater than 35dB are identified by the MSDH for appropriate interventions to ensure the best possible speech and language development. Children who are eligible by age are followed by the Early Intervention Program, and older children are referred to the Department of Education. Through collaborative efforts, a system of tracking has been developed to follow children referred into the system. In FY 1999, approximately 55 percent received appropriate follow-up and intervention upon hospital discharge. The exact number of infants actually receiving appropriate follow-up is unknown primarily because some hospitals are failing to give appointment cards for follow-up, and some audiologists are actually seeing the infants but are not reporting follow-up services. The MSDH plans to resolve this problem by conducting inservice workshops to educated and train hospital staff and audiologists on reporting procedures and use equipment on infants and toddlers 0-3.

NPM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. According to the Mississippi Division of Medicaid's Annual Fiscal Report for FY 1998, 88.0percent of potentially Medicaid eligible children have received a service paid by the State's Medicaid program.

NPM #16: The rate (per 100,000) of suicide death among youths 15-19. In 1998, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 9.1, which

represents a decrease from the 1997 rate of 11.8, but is still slightly above the Year 2000 Objective of 8.2 per 100,000. Since adolescents rarely use preventive health services, special efforts are made to reach them in the schools by placing school nurses in selected school systems around the state. Public health and school nurses are available to provide counseling and referral services to youth identified to be at risk. They also act as a school and community resource for health education and are expected to assist in bridging the communication gaps between adolescents and their families.

Services for CSHCN

NPM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care. According to an analysis conducted by the Children's Medical Program (CMP), which is the central office location for CSHCN, in FY 1999, 71.6 percent of its patients are covered by Medicaid, 11.3 percent are covered by private commercial insurance, and 17.1 percent have no source of insurance for primary and specialty care.

The possibility of establishing and/or developing a system for tracking and monitoring the status of CSHCN is currently being considered by MSDH representatives within the Bureau of Child Health, which administers the CMP for CSHCN.

NPM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. The Mississippi State Department of Health's Children's Medical Program has a history of families with children with special health care needs providing program and policy input. Program and policy input from CSHCN families has included representation on advisory committees where individuals provide input and/or feedback that is both solicited and unsolicited. Three parents of CSHCN are members of the Children's Medical Program Advisory Committee and provide program input along with physicians and other CMP professional and non-professional providers.

2.5 Progress on Outcome Measures

Outcome Measure #1: The infant mortality rate per 1,000 live births: In 1998, the overall infant mortality rate was 10.2, which showed a decrease from the 1997 rate of 10.6.

Outcome Measure #2: The ratio of the black infant mortality rate to the white infant mortality rate: The ratio of the black infant mortality rate to the white infant mortality rate continues to be almost double. The decrease in the overall infant mortality rate was due to a decrease in the white rate - 7.1 in 1997 and 6.4 in 1998. The black rate showed a slight decrease - 14.6 in 1997 and 14.5 in 1998.

Outcome Measure #3: The neonatal mortality rate per 1,000 live births: In 1998, the neonatal mortality rate decreased from the 1997 rate of 6.5 to 6.2. Both races experienced rate decreases; the white rate decreased from 4.4 in 1997 to 3.3 in 1998 and the nonwhite rate decreased from 8.9 in 1997 to 9.5 in 1998.

Outcome Measure #4: The postneonatal mortality rate per 1,000 live births: The overall postneonatal mortality rate decreased from 4.1 in 1997 to 4.0 in 1998. The white rate increased from 2.7 in 1997 to 3.0 in 1998, and the nonwhite rate decreased from 5.7 in 1997 to 5.0 in 1998.

Outcome Measure #5: The perinatal mortality rate per 1,000 live births: The perinatal mortality rate per 1,000 live births in 1998 was 12.4, which represents a decrease from 14.4 in 1997.

Outcome Measure #6: The child death rate per 100,000 children aged 1-14: The child death rate per 100,000 children in Mississippi aged 1-14 in 1998 was 42.0, which represents an increase from 36.3 in 1997.

The goals of the National and State performance measures of assessing needs, assuring access, policy development, and evaluation are interrelated with the agency's goal of employing the core functions of public health in providing services for the entire Title V population.

In an effort to carry out the core functions of public health, the MSDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MSDH accomplishes this through the agency's goals of:

- assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems;
- developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and
- assuring access to essential health services.

In areas where the MSDH is not the primary provider of care, the MSDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MSDH provides the support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics until delivery and then return to MSDH for postpartum and family planning services after delivery. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MSDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

Between FY 1994 (23,882) and FY 1998 (13,591), there has been a 43 percent decrease in the number of maternity clients seeking prenatal care at county health departments. This decrease has been due to the proliferation of rural health clinics and the implementation of the Medicaid managed care program, HealthMACS. In some counties in which HealthMACS is in place, no prenatal patients are seen in the county health department clinics. In other counties, the prenatal patient is seen in the health department until she gets her Medicaid card and is assigned a primary care provider.

The MSDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

When individual or family needs exceed what is available through the public health system, referrals are made to other public or private providers of health and social services. The MSDH has demonstrated an ability to achieve healthy goals in spite of limited resources. Health outcomes such as the reduction in infant mortality, high immunization levels, improvement in prenatal care, and other goals have been reached through the labor of the MSDH's statewide team and good working relationships between other state agencies (see form # 12 for health outcome measures).

III. REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Mississippi's Title V MCH Needs Assessment involved a year long process for MSDH Staff. Highlights of this process included: training regarding needs assessment

among central office staff and then capsulates each with the block grant work group, a committee composed of various staff from every MSDH districts; development of the needs assessment plan while writing the SSDI Grant; a state-wide conference regarding needs assessment for both district and central office staff; data collection in the districts; report of major needs assessment findings; and prioritization of problems among population groups by central office and MCH block grant work group members. Block grant work group members also reviewed the new state performance measures and participated in the process by listing activities that they would carry out in order to meet the goals in the state performance measures. The process used in this needs assessment has been much more inclusive than the process used in the past. There has been much more involvement of the various central office MCH staff and block grant work group staff, which are located throughout the State of Mississippi.

3.1.2 Needs Assessment Content

The plan for data collection involved collection at both the state level and the District level. The state level data included the usual MCH data obtained from vital statistics, national performance measures and outcomes, and the previous state performance measures. For each performance and outcome measure, staff reviewed data projections, the respective 2010 objective, the trend in the state's performance indicators, and the comparison of Mississippi's progress with other states in the southeastern region.

Other special topics investigated at the state level included maternal mortality, youth violence, adolescent health indicators, projections in changes among Hispanic populations in Mississippi, and smoking among pregnant women.

Data collected at the district level focused on three questions. The first question was, "Who has the problem?". This question was targeted toward the districts to identify subpopulations that may not be identified in state level evaluation. Of particular interest were groups who might have gaps in their health status for a variety of reasons. The second question was, "What MCH services exist?". In this section, Districts reported existing MCH services that included both MSDH services and non-MSDH services. Again, districts were asked to identify gaps in services that existed in their area. The third question was, "What do consumers say?". In this section, the districts were to report cultural or language characteristics of consumers that were different from the norm and satisfaction of consumers. Districts were also to report consumer expressed need and gaps in services that consumers identified.

An array of others sources were used in the collection, synthesis, and analysis of data. In an effort to assess health status, health care access, delivery systems and assurance needs, existing or secondary data was the most common source of data used. These data sources were supplemented and updated through recent surveys, such as the immunization survey, and key informant interviews with individuals in a variety of

agencies. Data sources from in-house systems include data from Vital Statistics, the Patient Information Management System (PIMS), the WIC Automated Data Processing System, the Children's Medical Program (CSHCN) Patient Information System, and other program-specific information sources, both automated and manual. External sources such as the Mississippi Division of Medicaid, Department of Human Services, Department of Rehabilitative Services, University of Mississippi Medical Center, and others were used to augment these data, as needed.

Specific documents or publications from which information was drawn included the 1998 Kids Count Data Book-State Profiles of Child Well-Being, Selected Statistics on Health Professional Shortage Areas,(June 16, 1999), Behavioral Risk Factor Surveillance System (1998, 1999), Selected Facts About Teenage Pregnancy (1998, 1999), and Mississippi Youth Risk Behavior Survey (1999).

Data were examined relevant to: size, locations, and characteristics of the target populations; barriers to care; program eligibility of the target populations, including income, risk status, and source of payment for care; and availability/accessibility of health care providers. This examination identified major health problems and factors contributing to them, existing health resources and systems available to address them, and gaps between problems and services.

Limitations of Data. The most obvious limitations relate to data that are subject to rapid/frequent change such as health manpower and health facilities participating under Medicaid. Other important data limitations relate to the challenges faced in acquiring data from outside sources, and the absence of a reliable estimate of potential CSHCN in Mississippi due to an absence of a statewide morbidity registry for children. Lack of more extensive primary data is a notable weakness; it would have been helpful to have conducted additional surveys of clients' perceptions based on individual ease or difficulty in accessing health care. Finally, although some data reflect the latest data available, it is not current.

3.1.2.1 Overview of the Maternal and Child Health Population Health Status

Mississippi is a predominately rural state with approximately three-quarters of the 2.6 million state residents living in non-metropolitan areas. On the south, it borders Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties occupy 47,715 square miles. The racial composition of Mississippi residents is mixed, with three fifths of the residents white and about two-fifths African-American. Mississippi has the largest portion (nearly 40 percent) of African-American residents among all

the states. The Hispanic and non-citizen immigrant populations are small but growing, as Cubans and Central Americans have been brought in to work for the poultry, forestry, and construction industries in the state. Mississippi has 290 incorporated cities, towns, and villages. While three-fourths of Mississippi's citizens reside in one of these incorporated places, statistics reveal that over 52 percent of the state's population live in rural areas. The rural nature of Mississippi makes it very important that health care resources be appropriately targeted to the areas of greatest need. Less than 20 percent of Mississippians reside in one of the eight cities with a population of 25,000 or more, and only one-third live in cities of 10,000 or more residents. The state has three standard metropolitan statistical areas (SMSAs): Biloxi-Gulfport (Hancock and Harrison Counties), Jackson (Hinds, Madison, and Rankin Counties), and Pascagoula-Moss Point (Jackson County). DeSoto County is included in Memphis SMSA.

Mississippi is, and has been for many years, one of the poorest states in the nation. Almost one-fifth of the population (17.1 percent) was below the Federal poverty level (FPL) in 1998. One-third of Mississippi's children live in poverty, which exists in both urban and rural areas of the state. The majority of children living in poverty reside in the western portion of the state. Four counties have child poverty rates of 60 percent or greater, Holmes (68.0 percent), Tunica (67.3 percent), Issaquena (62.3 percent), and Humphreys (60.0 percent). In 1989, there were 28 counties in which between 40.1 percent and 68 percent of the children were living in poverty.

According to 1998 data from the Census Bureau, child poverty has dropped below 20percent for the first since 1980. Currently, approximately 18.9 percent of Mississippi's children under 18 live in poverty. These rates are about 69 percent higher than the national average. A substantial share of employment is agricultural work. Mississippi's per capita income in 1998 was 28 percent below the national average. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state.

On the positive side, Mississippi has had a vigorous economic boom for several years. The state's per capita income grew 19 percent between 1994 and 1998, almost level with the national growth rate of 20 percent. One factor in the state's stable economic environment has been the construction of casinos, which has helped revitalize some areas of the state. Mississippi has also been able to attract other businesses, helped by the low cost of living and other favorable business conditions.

According to the Mississippi Employment Security Commission's AMR-1 Report for November, 1999, employment increased from 1,281,000 in November 1998 to 1,285,000 in October 1999, representing a 0.3 percent increase, while the unemployment rate decreased to 3.8 percent from 4.4 percent. The average civilian labor force was 1,268,700 for the 12-month period ending October 1999.

Four counties in Mississippi recorded double-digit unemployment rates in November, 1999. Forty-eight counties reported unemployment rates of less than five percent, compared to 37 the previous year. Jeff Davis County reported the highest unemployment rate for the month at 15.1 percent, followed by Holmes at 14.4, Jefferson at 13.2 and Issaquena at 10.8 percent. Lafayette County had the lowest rate at 1.1 percent, followed by Oktibbeha at 1.5, Rankin at 1.6, and DeSoto at 2.0 percent

The state treasury has also fared very well. In addition to revenue growth as a result of general economic development, legalized gambling has brought in additional tax revenues. Reflecting its strong fiscal position, Mississippi had a rainy day fund of about $236 million as of 1999.

While the economic outlook for Mississippi has become more positive in recent years, the state remains one of the poorest in the nation. The state has a relatively high poverty rate and there are inadequate transportation resources available statewide for women and children to access medical care. The lack of transportation contributes to the difficulties many poor people encounter in obtaining care. Urban transit systems serve the Jackson, Hattiesburg, and Biloxi/Gulfport areas, where taxi service is also available. Rural transit systems consist of elderly/handicapped buses operated by a variety of community agencies.

Other barriers to adequate health care include the lack of access to the health care system, a growing culturally diverse population, and lack of coverage for preventive health services. Possible solutions include promoting health education for providers, funding services and programs targeting needy populations, and evaluating the effectiveness of these services and programs.

A lack of health insurance coverage, under-insured, and inadequacies in coverage limit access to health care providers and facilities. Nonwhites use hospital emergency rooms and clinics much more often than do whites. Approximately 20 percent of African-Americans, compared to 13 percent of whites, report no usual source of receiving medical care. African-Americans are more likely to be Medicaid recipients and more likely to be uninsured, due largely to their employment status. Rural areas, particularly those with a high concentration of poor African-Americans, often have very few medical resources. This fact further limits access to primary health care. As of April 1999, 63 counties or portions of counties in Mississippi were designated as health professional shortage areas (HPSAs) for primary medical care.

According to the Census Bureau's 1998 population estimate, Mississippi has a population of 2,752,092. Census data also revealed that Mississippi's population is 63.5 percent white and 35.6 percent African-American, with approximately 1.0 percent other races. In 24 counties, located mostly along the Mississippi Delta,

minority populations exceed 50 percent. In 21 counties, located primarily in the northeastern and southeastern corners of the state, the populations were less than 25 percent minority. Ten counties had 1.0 percent or more in the "other races" category. An estimated 6,500 people of Asian/Pacific origin reside in the coastal region. Most of the Mississippi Band of Choctaw Indians live in the seven counties with designated reservations in East Central Mississippi counties. The MSDH conducted a special study in which projections of Hispanics in Mississippi were examined. This is an important sub-group to monitor because a large proportion of Hispanics in the United States live in poverty, have less than a high school education, lack health insurance, and are less likely to receive adequate preventive and primary care services. Mississippi also lacks a work force that possesses language skills to be able to adequately communicate with this subgroup.

Included in the appendices is a chart revealing the Hispanic population estimates from 1998 that shows that Mississippi is projected to have 22,755 Hispanics. The figures show shaded counties, which represent the top twenty counties with an estimated Hispanic population greater than 250 (see chart in appendices).

These estimates show that men constitute 40 - 50 percent of the Hispanic population, thus, the rest are women and children. A review of MSDH services reveals an increase in WIC, Child Health, and Family Planning services to Hispanic populations. The MSDH also had a slight increase in its services to Hispanics in pregnancy high risk management.

With so much poverty and high unemployment, there is reduced access to health care in Mississippi. Individuals do not have the dollars to pay for health insurance nor are there sufficient opportunities to obtain health insurance through employment or through publicly funded programs such as Medicaid. Because so great a proportion of the state's population live below poverty and is dependent on transfer payments, and because the number of unemployed is so high, Mississippi's tax base has not expanded sufficiently to meet the needs of the state's low-income citizens. Mississippi has the lowest tax capacity index among southern states and Mississippi ranks next to last among southeastern states in expenditures for health care.

High quality health care services depend on the availability of competent health personnel in sufficient numbers to meet the population's needs. Mississippi is traditionally a medically underserved state, particularly in sparsely populated rural areas and areas containing large numbers of poor people, elderly people, and minorities. Data on health manpower show that among the southeastern states, Mississippi ranks the lowest in physician to population ratio. There is only one primary care physician for every 1,310 persons.

Birth Rate Data

Mississippi experienced a 3.2 percent increase in live births from the previous year. In 1998, there were 42,917 lives births compared to 41,527 registered in 1997. Of these, 53.5 percent (22,950) were white and 46.5 percent (19,967) were nonwhite. More than 99 percent of the live births occurred in the 15-44 year age group. Over 45 percent of all live births (19,500) were among unmarried women; 76 percent of these births were to nonwhite mothers. Mothers under the age of 15 gave birth to 284 children; 90.5 percent (257) were nonwhite and unmarried.

The birth rate in 1998 was 15.6 live births per 1,000 women. The fertility rate was 68.2 live births per 1,000 women aged 15-44 years. The table below provides information on birth and fertility rates in Mississippi for the past five years by race.

Live Births, Birth Rates, and Fertility Rates 1994-1998

	1994	1995	1996	1997	1998

Live Births	41,938	41,332	40,978	41,527	42,917
White	21,536	21,571	21,447	22,021	22,950
Nonwhite	20,402	19,761	19,531	19,506	19,967
Birth Rates	16.3	15.3	15.2	15.4	15.6
White	13.2	12.7	12.7	13.0	13.3
Nonwhite	21.7	19.8	19.5	19.5	19.3
Fertility Rates	70.2	65.8	65.2	66.1	68.2
White	59.5	58.3	57.9	59.5	62.9
Nonwhite	86.4	76.5	75.6	75.5	75.7

Slightly more than 72 percent or 30,927 of the 42,917 total live births in 1998 were born to "at risk" mothers. The top ten counties for percentage of infants born to mothers at risk were: Noxubee, Jefferson, Newton, Panola, Montgomery, Issaquena, Coahoma, Wayne, Tunica, and Tallahatchie. "At risk" factors include mothers:

1. who are under 17 years or above 35 years of age;
2. who are unmarried;
3. who have completed fewer than eight years of school;
4. who have had fewer than five prenatal visits;
5. who began prenatal care in the third trimester;
6. who have had prior terminations of pregnancy; or
7. who have a short inter-pregnancy interval (prior delivery within 11 months of conception for the current pregnancy).

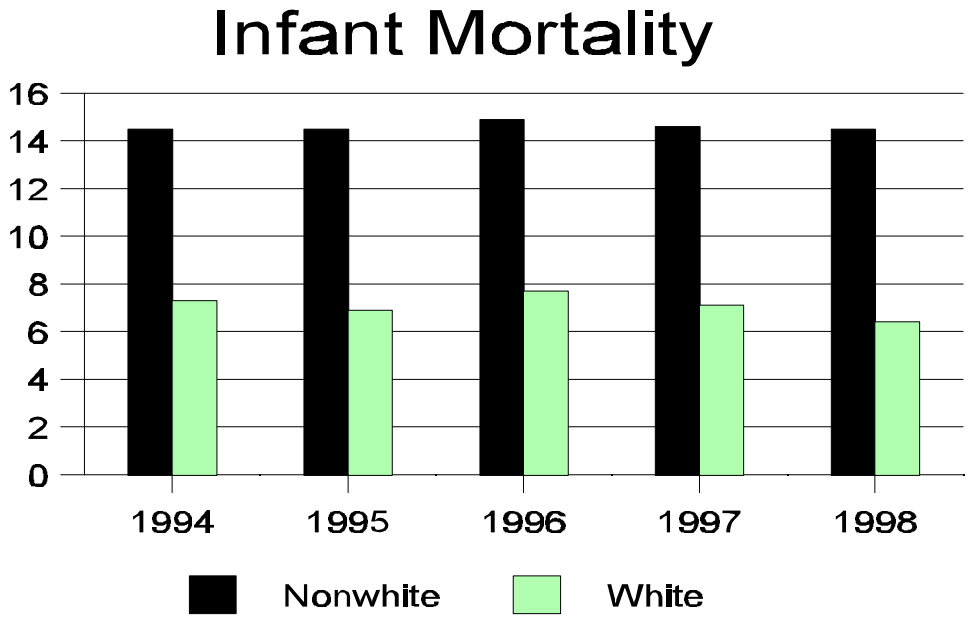
Mississippi has one of the highest percentages of births to teenagers in the nation, at 20.0 percent of all live births. A total of 8,598 children were born to teen mothers in 1998. The percentage was slightly below the percentage of 20.6 reported in 1997. The teen pregnancy rate for adolescents was 83.7 per 1000 for female 15-19 years old and 3.5 per 1000 for 10-14 years old. These rates represent a total of 9,891 reported adolescent pregnancies in the state. However, teen pregnancy rates for girls under age 15 decreased slightly. The rates for white teens age 15-17 remained steady, and the rate for nonwhite teens aged 15-17 have been gradually declining since 1991. Pregnancy rates for older teens aged 18-19 follow the same trend as younger teens. Although Mississippi teen pregnancy rates have demonstrated a downward trend since 1991, they still remain too high.

Approximately 30 percent, or 2,572, of the 8,598 live births to Mississippi teens in 1998

were to teens who had already had at least one previous birth. 6,019 births were first births; 1,975 the second; 487 the third; and 110 the fourth or more births.

Infant Mortality

The infant mortality rate in Mississippi has declined since 1980 although not consistently. The chart below shows the mortality rate for nonwhite infants is more than twice that for white infants, which is 14.5 deaths per 1,000 live births to 6.4 for whites. This disparity is comparable to national figures.



In the five-year period from 1994 to 1998, thirty-seven counties in Mississippi had infant mortality rates above the five year state average of 10.6 per 1000 live births. Only one of the ten counties with the highest infant mortality rate had a lower rate of live births to mothers-at-risk than did the state at large; the other nine counties had higher rates. Coahoma County reported the highest incidence of live births to teenagers while Tallahatchie County had the highest rate of low birthweight infants. The table below (Table II) lists the ten counties with the highest average infant mortality rates for this period. These counties account for 9.8 percent of the State's total live birth in 1998.

Table II Mississippi Counties Experiencing the Highest Infant Mortality Rate 1994-1998 5 - Year Average			
State/County	Rate		
	Total	White	Non-White
Mississippi	10.6	7.1	14.6
Noxubee	24.9	4.0	31.2
Jefferson	20.2	22.7	20.1
Newton	19.6	12.4	28.0
Panola	19.6	12.5	24.0
Montgomery	19.0	10.8	24.6
Issaquena	18.0	40.0	11.6
Coahoma	16.8	6.8	19.2
Wayne	16.6	11.9	21.2
Tunica	16.4	-0-	19.7
Tallahatchie	14.7	3.0	19.4
Rate per 1,000 live births Source: Vital Statistics Mississippi. 1998. MSDH Bureau of Public Health Statistics			

Low birthweight (LBW) is a leading cause of infant mortality and mental retardation. Factors associated with low birthweight may include a lack of prenatal care, poor nutrition, mother's lack of formal education, abject socioeconomic status, smoking, alcohol or drug abuse, and age of the mother. In 1998, 19.3 percent of births were either low birthweight or premature. These indicators differ markedly by race of the mother. Low birthweight was 87.5 percent higher among nonwhite mothers (7.2 for whites vs. 13.5 percent for nonwhite). The rate of births that were either low birthweight or premature was 63.1 percent higher among nonwhite mothers (14.9 percent for whites vs. 24.3 percent for nonwhites). National studies have shown that teenagers are more likely to deliver low birthweight babies and this is the case in Mississippi. In 1998, 11.9 percent of the births were low birthweight and 16.9 percent were premature.

In 1998, Mississippi had one of the highest percentages of low birth-weight babies, the highest infant mortality and child death rates, and the highest rate of teen deaths by accidents, homicide, and suicide of all 50 states, according to the 1998 Kids Count Data Book. For older children and adolescents, however, the state had lower juvenile crime arrest rates than 37 other states, although this rate has increased in the state over the past 10 years. Overall, Mississippi was ranked second to last among the states in a composite rating of 10 selected measures of child well-being.

Because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget, with the federal government providing nearly three dollars for every two dollars of state funds for overall expenditures in 1996. Nevertheless, the current rapid economic growth signals that conditions are improving, and the state has fiscal resources that could be used to further improve the situation.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Department of Economic and Community Development (DECD), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state governmental structure.

These economic factors have influenced the Title V delivery system. In addition, the MSDH has begun to realize the impact of Medicaid's mandatory managed care program (HealthMACS) through a reduction of patients seen in the health department system. Also, welfare reform is being felt by a reduction in the overall number of Medicaid eligible recipients in the State.

The State Legislature created a Child Health Insurance Task Force in 1998 to develop a state plan for the implementation of a Child Health Insurance Program (CHIP), which began providing coverage in late 1998 to children 15 through 18 years of age between 33percent and 100percent of the federal poverty level (Phase I). A state plan to further extend coverage to all children between 100 percent and 200 percent of the federal poverty level was approved by HCFA in February 1999. Implementation of Phase II began in January, 2000.

This new coverage for children will continue the evolution of child health services for the next few years.

In addition, Medicaid has created a mandated managed care exemption for Children with Special Health Care Needs (CSHCN) which sets the stage for the CSHCN program to be the primary case manager for the future of the special needs population, and should continue with the development of the new CHIP program.

Health Status

The examination of the health status of women and children was used to provide the basis for planning their health care. The examination was guided by the principles that; 1) mothers and children be given high priority in any system of care, and 2) that the health care for mothers and children be available to everyone. A third underlying principle would involve the development of a network of local organized community services to provide primary health care to mothers and children and speciality care as needed.

Maternal Health

In 1998, there were 42,917 live births in Mississippi, 22,950 to white mothers and 19,967 to non-white mothers.

Table 1. 1998 Mississippi Pregnancy Statistics

	All Races	White	Non-White
Births (Rate*)	42,917 (15.6)	22,950 (13.3)	19,967 (19.3)
Fetal Deaths (Rate**)	427 (9.9)	147 (6.4)	280 (13.8)
Induced Abortions****	3,955	1,215	2,737
Fertility Rate***	68.2	62.9	75.6

*Per 1,000 total population
**Per 1,000 live births + fetal deaths
***Live births per 1000 females age 15-44
****Total includes 3 induced terminations listed as unknown race.

Overall, 80.1 percent of pregnant women sought prenatal care in their first trimester of pregnancy, 88.9 percent of the white mothers and 70 percent of the non-white mothers. Using the Kotelchuck index to quantitative measure adequacy of prenatal care, 24.4 percent of Mississippi mothers did not receive adequate care (18.9 percent white, 30.8 percent non-white). Of these women, 12.6 had inadequate care (6.5 percent white, 19.6 percent non-white); the other women had care in the intermediate range. The percent of women who do not receive any prenatal care is small, and slightly decreasing. In 1994, 1.5 percent of women did not receive care; 1995 - 1.4 percent; 1996 - 1.4 percent; 1997 - 1.3 percent; and in 1998 - 1.2 percent did not receive care.

Table 2. Mississippi: Percentage of Women Receiving Prenatal Care in First Trimester

	1994	1995	1996	1997	1998
All Races	75.3	76.6	78.2	79.7	80.1
White	85.3	86.7	87.8	88.9	88.9
Non-White	64.7	65.6	67.6	69.3	70.0
<15	41.9	49.6	44.3	47.0	43.5
15-19	62.2	63.4	65.0	66.5	68.2
20-24	72.7	75.0	76.1	77.9	77.2
25-34	84.4	84.9	86.4	87.5	87.8
35+	75.0	82.8	83.3	83.6	86.1

Of the 42,917 births, 20 percent or 8,598 were to women under age 20. Girls aged 14 or younger gave birth to 285 infants. This has persisted over the past five-year period. These very young mothers are at risk both biologically and behaviorally. While prenatal care was initiated in the first trimester by 68.2 percent of 15-19 year olds, only 43.5 percent of those under 15 did so. This is slightly higher than the 1994 rates for 15-19 year olds (62.2 percent) and for those under 15 (41.9 percent). Rates of inadequate prenatal care among adolescents (as measured using the Kotelchuck index) are disturbing especially among the very young. Of women < 15, 45.3 percent had inadequate care (14.3 percent white, 48.6 percent non-white). 20.8 percent of women 15-19 had inadequate care (12.5 percent white, 25.9 percent non-white). In addition, other women had prenatal care in the intermediate range (7.0 percent < 15, 12.5 percent age 15-19. Over a quarter of births (27.2 percent) in Mississippi in 1998 were by cesarean section. This is higher than the 1998 national rate of 21.2 percent

Mississippi's WIC program is an incentive for early entrance into the expanded maternal and child health delivery system, and is an important component of a comprehensive preventive health service. Infants and children are eligible if they show signs of poor growth, anemia, obesity, chronic illness, or nutrition-related diseases. Pregnant and postpartum women are considered at risk if they are younger than 18 or older than 35, have a poor obstetrical history, are anemic, or gain weight at an undesirable rate.

The WIC program, in its effort to 1) improve the outcome of pregnancies, 2) reduce health problems associated with poor nutrition during pregnancy, infancy, and early childhood, and 3) reduce infant mortality, provides special supplemental food and nutrition education to low-income pregnant, postpartum, and breast-feeding women, infants and preschool children who have nutrition-realted risk conditions. The foods WIC provides are especially high in the nutrients protein, iron, calcium, and vitamins A and C.

During FY 1998, the WIC program served a monthly average of 22,925 pregnant, postpartum, and breast-feeding women, 44,814 children under the age of five years, and

30,661 infants. Eighty-seven percent of those served were in the top three priorities. The Mississippi WIC bureau has a participation rate of almost 92 percent of those enrolled.

The MSDH conducted an epidemiologic analysis of birth certificates to examine smoking behaviors reported among pregnant women. The sample included 120,429 single births to Mississippi residents from 1995 through 1997. Smoking among pregnant women in Mississippi is less than reported for the United States, and both the rate in Mississippi and in the United States have been decreasing from 1995 through 1997.

Smoking among pregnant women is associated with fetal distress, assisted ventilation, apgar scores less than five, low birth weight, and infant mortality. Each of these adverse outcomes are entirely preventable.

Further analysis revealed that pregnant women who smoke in Mississippi are similar to those in the United States who smoke. A higher proportion of smokers have less than a high school degree compared to women who do not smoke. Also, smoking is much more prevalent among white women. Consistent with what is reported over all the United States, the number of cigarettes reported smoked by Mississippi pregnant women has been declining since 1990. However, it is difficult to know how much this decline results from under-reporting due to the increased stigma associated with smoking. Furthermore, low birth weight is elevated even among women who are the lightest smokers (1 - 5 cigarettes per day).

Examination of smoking trends by age group also revealed that the pattern in Mississippi is consistent with the United States. There is a significant decrease in smoking among 25 - 29 and among 30 - 34 year old pregnant women. However, there is also significant increase in smoking among pregnant women age 15- 19 years old. This finding prompted the development of a State Performance Measure about smoking among pregnant adolescents.

The birth certificate data indicates that 1.9 percent of all mothers lost weight or gained no weight during pregnancy: white, 1.4 percent and non-white, 2.6 percent. Among those who gained weight, 9.1 percent gained 1-14 pounds; 22.0 percent, 15-24 pounds; 28.6 percent, 25-34 pounds; and 33.9 percent, more than 35 pounds. The median weight gain was 30.6 pounds: white, 32.2 and non-white mothers, 28.1. Weight gain of less than 21 pounds is associated with an increased likelihood of a LBW outcome.(Ventura et al, Monthly Vital Statistic, 1998).

Maternal Mortality

Maternal deaths are defined as deaths that occurred during pregnancy or within 42 days after pregnancy termination, regardless of pregnancy duration, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes. The national health objective is to reduce the overall maternal mortality ratio (MMR) #3.3 maternal deaths per 100,000 live births. Although the rate of maternal mortality in Mississippi is highest among states in the United States (U.S.), the actual number of women's deaths is low–ranging from 1-11 per year. However, the low numbers do not diminish the tragedy of the death of a mother

nor the sentinel importance of such a death. Furthermore, these deaths occur disproportionately, with African-American women having a four-fold increased risk for dying from a pregnancy-related cause compared with white women.

Mississippi's Maternal Mortality Rates (MMR) averages have consistently been higher than United States rates. The 1987-1996 rates were: Mississippi=12.3; US=7.7. The most recent Mississippi total and race-specific five-year averages (for 1994-1998) are:

Total=12.0
White=6.4
Nonwhite*=18.2

The following table details Mississippi's maternal mortality data for the last five years.

Year	Total	White	Nonwhite*	Total Rate	White Rate	Nonwhite* Rate
1994	4	1	3	9.5	4.6	14.7
1995	5	0	5	12.1	-	25.3
1996	1	0	1	2.4	-	5.1
1997	11	4	7	26.5	18.2	35.9
1998	4	2	2	9.3	8.7	10.0

*99percent of nonwhite are black.

Conclusions:

Because Mississippi's rates and the racial disparity is so high, the MSDH has launched a more intensive effort to address maternal mortality. An evaluation of the surveillance system revealed that the Division of Vital Statistics has added a check-box on the death certificate to record a recent pregnancy and uses additional methods to determine whether a death is pregnancy related. However, weaknesses in data collection and review procedures have been identified and the Women Health's Bureaus staff and the MCH epidemiologist are working together to enhance agency policy regarding the surveillance of maternal mortality, data collection materials and procedures, and the training of local Maternal/Child Health and Family Planning Coordinators.

PHRM/ISS

Using the Perinatal Risk Screening form, PHRM/ISS identifies factors that place a pregnant woman or infant at increased risk for a poor outcome. This will enhance birth certificate data and provide new data on some risk factors. Factors include medical and obstetrical history, complications of current pregnancy, and sociodemographic factors. In 1998, 3,773 pregnant and

postpartum women were considered at high risk using this instrument; and in 1999, 4,704 women were identified**.**

Substance abuse is a growing problem among pregnant women in Mississippi. In 1998, 760 substance-abusing pregnant and postpartum women were identified through the Perinatal High Risk Management/Infant Services System. In 1999, the number was 1,369, which may in part be due to more aggressive identification methods by PHRM/ISS and expansion of the program statewide. A portion of the increase may be due also to more aggressive identification of cigarette smoking as a substance abuse factor.

PHRM/ISS Risk Ranking for State

Prenatal - Postpartum			
Risk Factor	**FY-99**	**FY-98**	**FY-97**
Substance Abuse	**1**	**1**	**5**
EDC<14 months	**2**	**3**	**2**
Mother < 16	**3**	**2**	**1**
Low Weight Gain	**4**	**5**	**3**
Other Signif. Risk	**5**	**4**	**4**

Conclusions:
A better description of the perinatal risks for Mississippi may be derived from the PHRM/ISS data than birth certificates, since the data are collected on enrollment into prenatal care. It is especially true if the PHRM/ISS screening tool is used by all providers of perinatal care. These data may be useful in better defining the epidemiology of perinatal outcomes in Mississippi. However, the data links through the entire system have a long way to go. Data are not currently available to describe the health of the entire population.

Fetal, Newborn, and Infant Health
The infant mortality rate for Mississippi is historically one of the worst in the nation. According to 1998 Kids Count Data, Mississippi ranked 50th among the states and the District of Columbia. The top five causes of infant deaths were congenital anomalies, 18.1 percent; disorders relating to short gestation and low birthweight, 17.9 percent; Sudden Infant Death Syndrome (SIDS), 14.0 percent; respiratory distress syndrome, 5.0 percent; and infections specific to the perinatal period, 3.0 percent.

Consistent with the high rate of infant mortality is the high percentage of infants born under 2500 grams, low birthweight (LBW). In 1998, the national percentage was 7.6 overall, 6.5 for whites and 13.0 for African-Americans. The corresponding rates in Mississippi were

10.1, 7.2, and 13.5, suggesting a greater than average problem among whites in comparison to the national rate. The low birthweight rate has increased yearly from 1994 to 1998, from 9.9 to 10.1 of all live births. There was an increase among non-white mothers, from 13.1 in 1994 to 13.5 in 1998. LBW rates have changed little among whites - 6.7 in 1994 to 7.2 in 1998. Two percent of all births in the 1998 were very low birthweight (under 1500 grams): 1.2 percent of births to white and 2.9 percent of births to non-white mothers. During the 1994-1998 period, rates of infant mortality and low birthweight were higher for teenage mothers, especially those under 15 years of age.

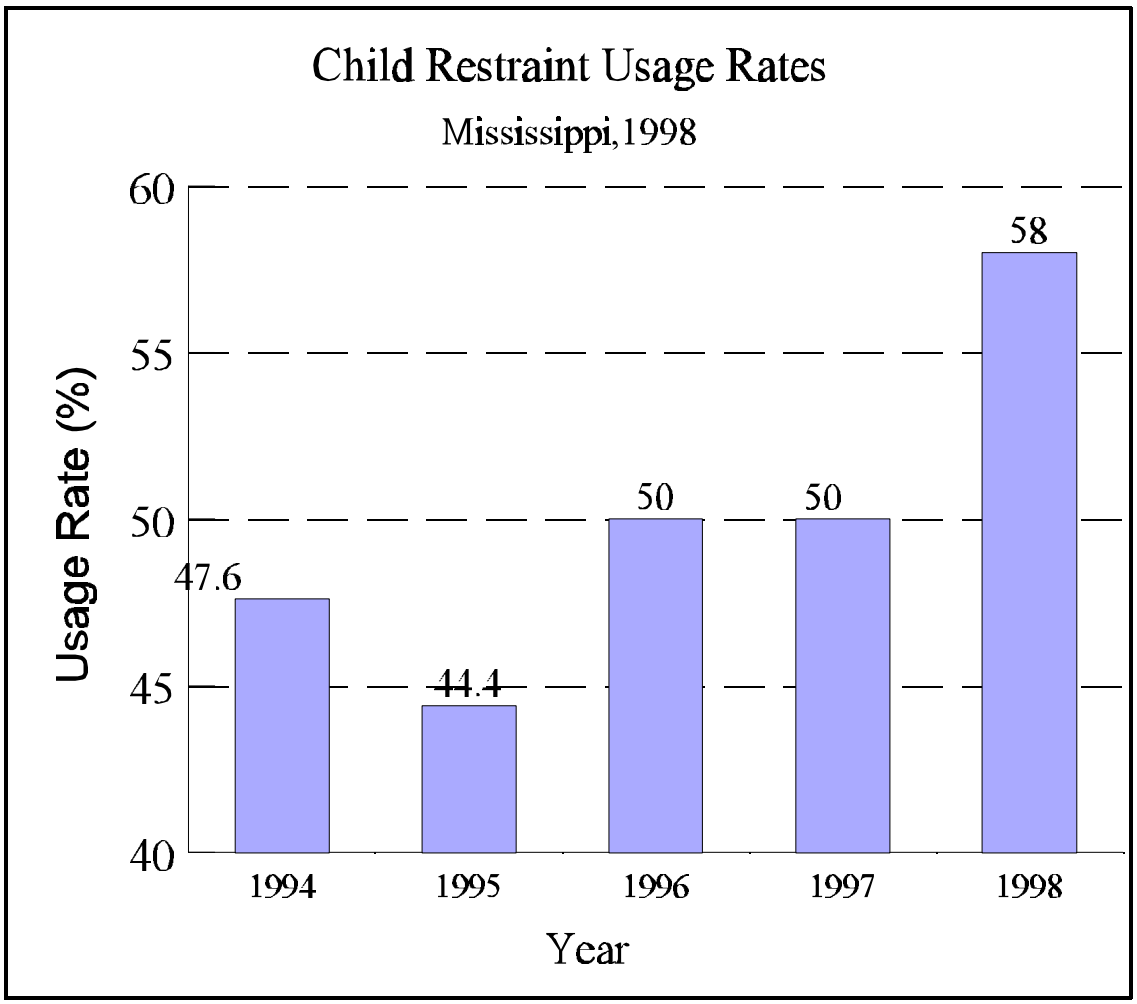
During FY 1998, 2,487 infants were identified as high risk by PHRM/ISS, and in 1999, 3,143. The most frequently occurring risks were low birthweight, low weight for length, neonatal intensive care over 7 days, mother's prenatal care less than 6 visits, and substance abuse.

Child Health

According to the 1998 Kids Count data, the death rate in Mississippi for children 1-14 years of age was 42/100,000 compared with the national rate of 28. Mississippi ranked 50th among the 50 states in childhood mortality. In 1998, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 9.1, which represents a decrease from the 1997 rate of 11.8, but is still slightly above the Year 2000 Objective of 8.2 per 100,000. Since adolescents rarely use preventive health services, special efforts are made to reach them in the schools by placing school nurses in selected school systems around the state. Public health and school nurses are available to provide counseling, and referral services to youth identified to be at risk. They also act as a school and community resource for health education and are expected to assist in bridging the communication gaps between adolescents and their families.

There were 92 deaths in 1998 among children age 1-4 years, a rate of 0.6 per 1000 children of that age. Injuries accounted for 46.7 percent of the deaths, followed by homicide and legal intervention (8.7 percent), heart diseases (4.3 percent), congenital anomalies (4.3 percent), cerebrovascular diseases (3.3 percent), and pneumonia and influenza (3.3 percent). Injuries accounted for 58.9 percent of the 151 deaths to children age 5-14.

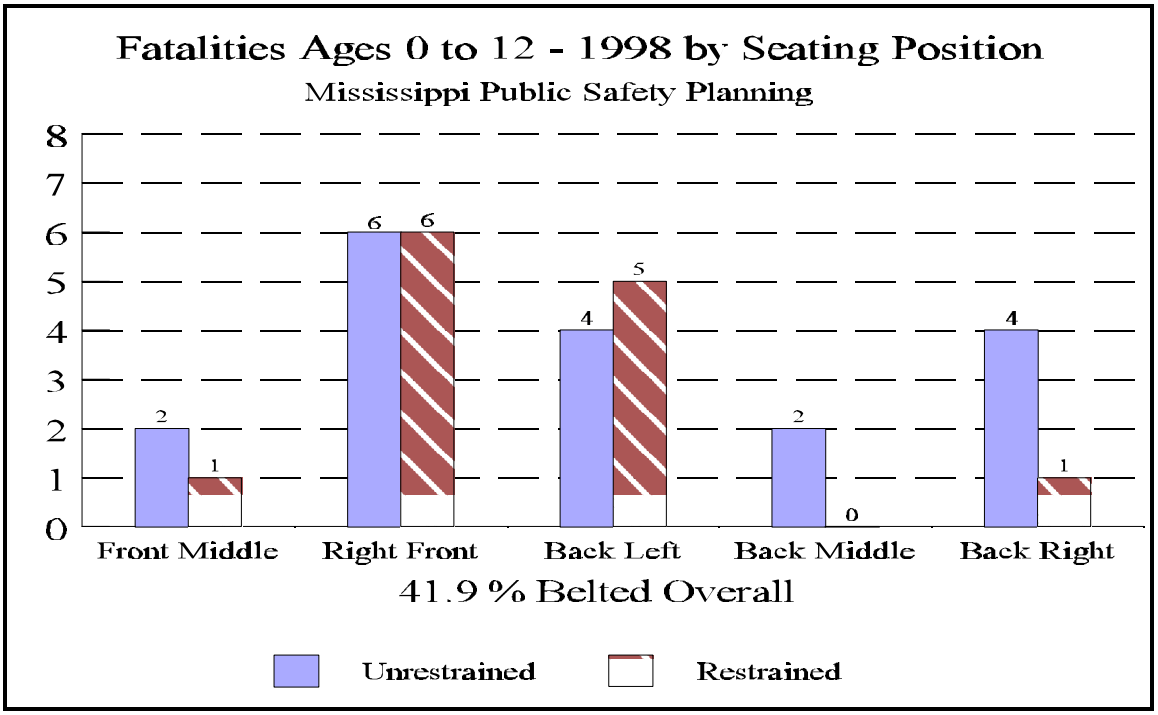
In 1998, thirty-nine children age 0-12 were killed in motor vehicle crashes. As indicated in the chart below, Mississippi's child restraint usage rate was 58 percent in 1998, indicating an increase from the 1997 rate of 50 percent (see chart below).



According to BUCKLE for Life project coordinator, University of Mississippi Medical Center, motor vehicle crashes are the number one cause of death and disability of children.

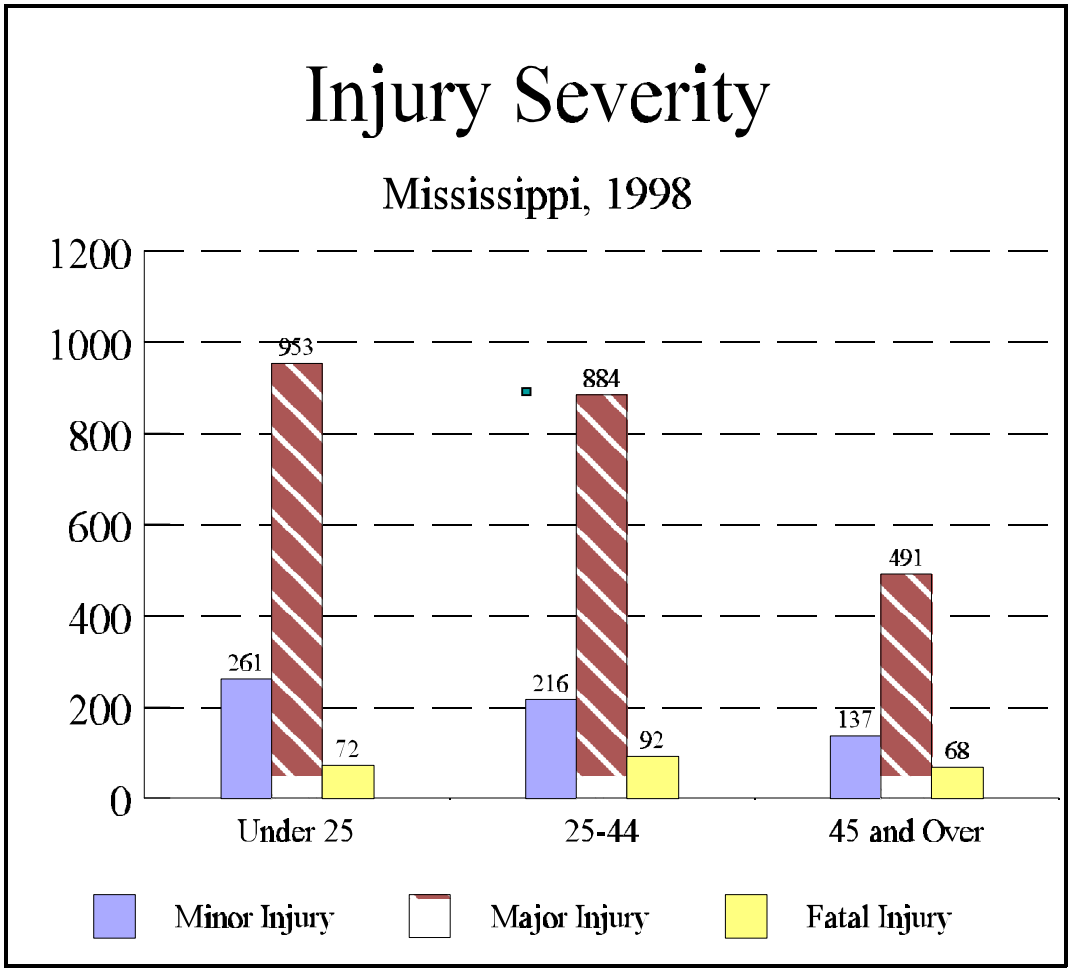
Every year approximately 1,000 children are seriously injured in Mississippi motor vehicle crashes, and approximately 30 up to age 8 die. Studies by the Mississippi Division of Public Safety Planning indicate that the correct use of vehicle child protective devises can reduce fatalities by 71 percent and injuries by 67 percent.

In February, 1999, eighty law enforcement officers were honored for encouraging motorists to buckle children into motor vehicle child safety seats at a BUCKLE for Life luncheon. These officers issued citations for violation of Mississippi's child restraint law which require that all children under 4 years of age be in child safety seats while traveling in private passenger vehicles, and every child who is at least 4 years of age, but under 8 years of age regardless of location inside the vehicle, wear a properly fastened safety belt system while traveling in these vehicles.



Over 6,256 children under age 14 were treated for nonfatal injuries. Of 3,174 patients entered with ages recorded in FY 1998 into the State Trauma Registry system, 41 percent

were under the age of 25. Listed below is the breakdown by age, sex, and race versus severity of injury.



I

mmunization Status

The 1998 immunization rate for two-year old children is one of the highest among the states at 84.2 percent, and is continually improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. Though nearly all infants began their immunizations on schedule, the survey indicated many did not complete them on schedule. Immunizations are required for all preschool and kindergarten through 12th grade students prior to school admission. Approximately 93.9 percent of children enrolled in licensed child care centers

and Head Start, and 99.3 percent of students in kindergarten through 12th grade were in

compliance with the requirements.

Mississippi is one of the first states in the nation to institute a state-mandated immunization registry. Immunization survey data indicate:

(a) 95.5 percent of students entering college have completed measles and rubella immunizations (1998 College Enterers Survey);

(b) 99.1 percent of first graders have completed four doses of diphtheria, three doses polio, and one dose each of measles, rubella, and mumps (1998 Assessment Survey);

(c) 84.2 percent of two year old children have completed four doses of diphtheria, three doses polio, and one dose each measles, rubella, and mumps (1998 Retrospective Survey of Two Year Old Children);

(d) 93.9 percent of children in child care facilities have completed four doses of diphtheria, three doses polio, and one dose each measles, rubella, and mumps (1998 Child Care Assessment Survey); additionally, 92.1percent of the children were immunized with four doses of diphtheria, three doses polio, and one dose each measles, rubella, and mumps, and 1 Hib.

Conclusions:
Mississippi has done an outstanding job in immunization efforts, creatively using Head Start, WIC, and CHCs, and nontraditional sites, such as National Guard armories, to help in the efforts. The immunization registry is a real asset in maintaining a leadership role in this area of public health.

The lack of adequate monitoring and follow-up of blood lead levels, poor nutritional levels and weight gains, and large numbers of childhood injuries as well as the low level of EPSDT screenings prohibit a more comprehensive preventive approach to child health. Increased monitoring may be possible as better data systems become available throughout the system.

Adolescent Health
The major cause of adolescent health problems in Mississippi, as in other states, is risk-related behavior. The problems associated with teenage pregnancy have been noted in a previous section and will not be repeated here. However, unintentional and intentional injuries were responsible for most deaths to 15-24 year olds. Injury is also one of the most serious social, economic and medical problems in public health. It is the leading cause of death among children in the United States, with more children and adolescents dying as a

result of injury than for all other causes combined. Injuries also result in lifelong disabilities.

Youth violence

According to the Centers for Disease Control and Prevention, youth violence is "the threatened or actual physical force or power initiated by an individual that results in psychological injury or death" and in which "the perpetrator, the victim or both are under 25 years of age". Based on the findings of the Mississippi Youth Risk Behavior Survey (YRBS), which was conducted in 32 public high schools in Mississippi during the spring of 1999, a substantial number of juveniles in this state are involved in some type of violent behavior, by physically fighting or by carrying a weapon. This survey was administered to 1,565 students, of which 51 percent were female and 49 percent were male, in grades 9 through 12. While 36 percent of the students surveyed in Mississippi in 1999 report that they had been in a physical fight in the past 12 months, 14 percent of the students surveyed had actually been in a physical fight *on school property* in the past 12 months. Twenty-three percent (23 percent) of the students surveyed in Mississippi in 1999 carried a weapon such as a gun, knife, or club during the past 30 days. Twelve percent (12 percent) of white students and 6 percent of African-American students reported carrying a gun in the past 30 days. In addition, 12 percent of male students and 2 percent of female students in Mississippi reported carrying a weapon *on school property* in the past 30 days.

According to the Office of the Mississippi State Attorney General, there were 750 juveniles in the state penitentiary in 1999. With regards to juvenile deaths, there were 100 juveniles ages 1-24 killed by homicide/legal intervention in Mississippi in 1998. Although this total is down from the 1997 juvenile homicide/legal intervention death total of 130 for youth ages 1-24, 1998 data reveals that homicide is the number two leading cause of death for juveniles in this state ages 1-24 (for the age sub-group of 5-14, homicide/legal intervention is tied with heart diseases and suicide). In 1998, the homicide/legal intervention rate in Mississippi was 19.2 deaths per 100,000 youth ages 15-24. This rate is lower than the 1997 Mississippi homicide/legal intervention rate of 25.3 deaths per 100,000 youth ages 15-24, but higher than the 1997 United States homicide/legal intervention rate of 16.8 deaths per 100,000 youth ages 15-24.

In addition to homicide/legal intervention, juvenile suicide is a leading cause of death of children and adolescents in Mississippi. In 1998, 67 Mississippi juveniles ages 5-24 died of suicide. This number is higher than the 56 juvenile suicide deaths that occurred in Mississippi in 1997. In 1998, suicide was the number two leading cause of death for children ages 5-14, with a rate of 1.9 deaths per 100,000 juveniles ages 5-14 (tied with homicide/legal intervention and heart diseases). Suicide was the number three leading cause of death for youth ages 15-24 in 1998, with a rate of 13.5 deaths per 100,000 youth ages 15-24. This rate is higher than the 1997 Mississippi suicide rate of 11.0 deaths per 100,000 youth ages 15-24, and higher than the 1997 United States suicide rate of 11.4 deaths per 100,000 youth ages 15-24.

During 1999, there were numerous efforts to decrease violence among youth in the state. The Mississippi State Department of Health hired a Violence Prevention Consultant to

investigate ways to address this public health issue. The Mississippi State Department of Education held three major conferences in which school employees, parents, law enforcement, and other community members from throughout the state met to address school violence and to learn conflict resolution techniques. In August of 1999, the State Department of Education began a "Connections" hotline, another endeavor by the agency's Office of Safe and Orderly Schools aimed at reducing youth violence. This hotline gives youth the opportunity to anonymously report threats of violence. The State Department of Mental Health is working to prevent violence among youth through the development of MAP Teams throughout the state. MAP Teams, which are made up of parents, teachers, and community agency representatives, identify those students who exhibit potential violent ior and design a plan to positively intervene in the lives of these youth. Through these activities and many other community level efforts, citizens of the state are working to prevent violence among youth.

For every injury death, there are an estimated 45 hospitalizations and 1,300 emergency room visits. The real tragedy is that most childhood injuries can be prevented through the use of existing technology and environmental changes. Injury data are essential for the development of appropriate injury prevention programs. Injuries, like infectious diseases, do not happen accidentally. They follow a pattern. The ground work for identifying that pattern begins with surveillance to find out what injuries are occurring, where and when they occur, and to whom. Information collected on injuries include variables such as age, race, type, and cause of injury. This level of detail can help identify populations at risk for specific injuries and help focus injury prevention efforts.

In Mississippi, according to the latest data published by the Mississippi Databook of Child and Adolescent Fatal Injury, 3,159 children and adolescents under the age of 25 were killed as a result of injury between 1993 and 1997. Estimated costs totaled nearly $3.7 billion and 190,127 years of potential life lost. Mississippi had the highest rates of injury deaths in the southeast region for all age groups except for children younger than one year in which the Mississippi rate was second highest.

In 1998, the causes of death for Mississippi youth, ages 14 - 24, were accidents, homicide and legal intervention, and suicide. The Mississippi accident death rate per 100,000 youth, ages 15 - 24, rose from 58.2 in 1997 to 63.5 in 1998. The 58.2 figure for 1997 was below the United States death rate overall for that population, which was 65.7. The Mississippi homicide and legal intervention death rate per 100,000 youth, age 15 -24, of 25.3 in 1997 was significantly above the United States rate for that year, which was 16.8 for age 15 - 24 years in 1998. Fifty-eight of the total number were non-white males, twelve were non-white females, nine were white males, and five were white females. These data appear to reflect some racial disparity.

Mississippi's suicide death rates per 100,000 youth ages 15 - 24 rose from 11 in 1997 to 13.5

in 1998. The 1997 figure of 11 from Mississippi compares favorably with the United States report of 11.4 for that year. A breakdown of the adolescent deaths due to suicide in youth age 15 - 24 years for the year of 1998, revealed that 44 were white males, 3 were white females, 11 were non-white males and 1 was non-white female.

Adolescent health data was gathered from several other sources, including the Youth Risk Behavior Survey (YRBS). The 1999 YRBS involved 1,565 students in grades nine through twelve in thirty-two Mississippi public high schools. In addition to measuring youth violence and suicide, other risk factor such as the use or participation in tobacco, alcohol, drugs, sex and physical activity were also measured through the YRBS.

Tobacco use was measured in several ways, the first of which is the percentage of students who smoke cigarettes on one or more of the past thirty days. This percentage was reported at 35 for 1995, 31.3 percent for 1997, and 31.5 percent for 1999. The percentage of students who smoke cigarettes, one or more over the past thirty days, for the United States was 36.4 percent in 1997. Mississippi has a favorable comparison on this particular measure. A related measure is the percentage of students who smoke a whole cigarette for the first time before age thirteen. In 1995, for Mississippi, 26.9 percent was reported; in 1997, 23.1, and in 1999, 25.8 percent. This compares to an overall reported rate for the United States of 24.8 percent in 1997. A related tobacco measure involved the percentage of students who use chewing tobacco or snuff on one or more of the past thirty days. This percentage was reported to be 10.1 percent in 1995, 6.8 percent in 1997, and 8.2 percent in 1999. The overall rate reported for the United States for 1997 was 9.3 percent.

The first measure for alcohol use is the percentage of students who had at least one drink of alcohol on one or more of the past thirty days. For Mississippi, the percentage reported in 1995 was 48.5 percent, for 1997, 46.4 percent, and for 1999, 42.5 percent. The overall rate for the United States was 50.8 percent in 1997. Another measure was the percentage of students who had their first drink of alcohol other than a few sips before age thirteen. For Mississippi the percentage reported was 29.9 percent in 1995, 36.2 in 1997, and 33.9 in 1999. The overall rate for the United States was 31.1 percent in 1997.

There were several related measures for drug use among adolescents in Mississippi. The first is the percentage of students who used one or more times during the past thirty days. This percentage for Mississippi was reported at 16.4 percent in 1995, 21.3 in 1997, and 18.9 in 1999. This compares to an overall United States marijuana usage rate of 26.2 percent in 1997. A related marijuana measure looks at the percentage of students who tried marijuana for the first time before age thirteen. The reported percentages for Mississippi were 4.8 percent in 1995, 8.8 in 1997, and 8.3 in 1999. This compares to an overall percentage in the United States of 9.7 percent in 1997. A related drug measure looks at the percentage of students who were offered, sold, or given an illegal drug on school property by someone during the past twelve months. For Mississippi the percentage reported was 20.2 percent in 1995, 24.1 in 1997, and 19 in 1999. The overall percentage reported for the United States

was 31.7 percent in 1997.

Sexual behavior had several related measures for adolescent self-reporting. The first was the percentage of students who have had sexual intercourse. The results were reported to be 67.6 percent in 1995, 69.5 in 1997, and 60.3 in 1999. The overall average reported for the United States was 48.4 percent in 1997. A related measure looked at the percentage of students who had sexual intercourse for the first time before age thirteen. The results reported for Mississippi were 18.2 percent in 1995, 21.2 in 1997, and 16 in 1999. This compares to an overall United States average of 7.2 percent in 1997.

Another related sexual behavior measure looked at the percentage of students who had sexual intercourse during the past three months, and of those, the percentage who used a condom during the last sexual intercourse. The data reported on Mississippi was 57 percent in 1995, 62 in 1997, and 58.4 in 1999. The overall rate reported for the United States was 56.8 percent in 1997. A measure also looked at the percentage of students who had ever been taught about AIDS or HIV infection in school. In Mississippi, 83.3 perecent in 1995, 86 in 1997, and 81.6 in 1999. The overall for the United States was 91.5 percent in 1997.

For the measure of physical activity, the percentage of students who exercised or participated in physical activities for at least twenty minutes that made them sweat and breathe hard on three or more of the past seven days were evaluated. For Mississippi, 51.9 percent answered positively in 1995, 53 in 1997, and 55.3 in 1999. This compares with the overall average reported for the United States of 63.8 percent in 1997.

Conclusions:

Adolescent health indicators are poor and need a coordinated effort of education to reduce rising risky behavior. STD rates and a belief that condoms do not help prevent STD's are helping to increase perinatal risks. Intervals between pregnancies are short, and this is likely to add to the increasing infant mortality rate. Teen pregnancies are extremely high, while tobacco use and other substance abuse clearly are contributing to the poor health outcomes.

The Jackson Medical Mall, in addition to becoming a national showplace for “user-friendly” health services, has recently became noteworthy again for opening one of the country’s first family-oriented centers for the research and treatment of tobacco use by children and youth. Focusing on prevention and research, the center is expected to do much to save millions that would have been spent on illnesses resulting from tobacco use. Not only should it save lives by treating kids who smoke and stopping kids from smoking, but it may also help prevent young people from going on to use other types of drugs.

The center is being funded by a $3.5 million grant to the University Medical Center, which arose from $62 million Mississippi received from the tobacco industry, but is separate from the $4.1 billion settlement the state crafted.

Reproductive Health

The major reproductive health problems in Mississippi include unintended or poorly timed pregnancies, initiation of early sexual activity among adolescents, unprotected teenage sexual intercourse, and sexually transmitted diseases. One approach to estimating the possible number of women with reproductive health problems is to examine the number of pregnancies that may be unwanted or poorly timed: births to those under 18 and over 40 years of age, of high parity (greater than 4 births) and with a birth interval of less than 2 years; and induced abortions. In 1998, women under 18 years of age gave birth to 3,468 live infants and experienced 33 fetal deaths. Women over 39 years of age gave birth to 449 infants and there were 9 fetal deaths. Many of these pregnancies and births were probably mistimed or unwanted.

The 1999 YRBS revealed that one of six (16.0 percent) high school students reported they had been sexually active before age 13. More than four of 10 (44.8 percent) reported being sexually active during the past 3 months, and the percentage of students in Mississippi who have had sexual intercourse with one or more partners in the past three months (44.8 percent) was significantly higher than the percent of students nationally who have had intercourse with one or more people in the past three months (34.8 percent). One of seven (14.3 percent) of students who has had sexual intercourse during the past 3 months used birth control pills during their latest sexual intercourse. 8.4 percent of the students reported they have been pregnant or gotten someone pregnant.

For the first time in several years Mississippi is experiencing a decline in cases of syphilis (primary, secondary, and early latent syphilis cases of less than one year duration). A total of 733 cases were reported in 1999, a 20.7 percent decrease from the 885 cases in 1998. In 1995 there were 4,339 syphilis cases; 1996 - 2,272; 1997 - 961; 1998 - 885; and 1999 - 733 cases. During the same five year period, 88 percent of the total early syphilis cases were reported in African-Americans. According to data received from the Division of STD/HIV, in 1999, African-American females reported the highest number of cases (333) followed by African-American males (327). White females (26) and white males (19) reported the fewest number of cases. The majority of early syphilis cases are found in the 15-34 age group. For calendar year 1999, 63 percent (465 of 733) of all early syphilis fell into this age group. Nineteen percent fell into the 20-24 age range.

In 1999, Mississippi had 10,196 reported cases of gonorrhea. Like syphilis, gonorrhea is racially and ethically concentrated in the African-American population. During calendar year 1999, 9,466 (93 percent) of the 10,196 cases were reported in African-Americans. Only 646 (6percent) cases were reported in whites and less than one percent was reported in other populations. African-American females are at the highest risk for acquiring gonorrhea with 54 percent (5,469 of 10,196)of the cases, followed by African-American males with 34 percent (3,429 of 10,196) of the cases for Calendar Year (CY) 1999. Age grouping indicated that ages 15-19 reportedly have the highest number of cases (3,338), followed by

the 20-24 age group (3,303), and the 25-29 age group (1,433). Almost eighty percent of the gonorrhea cases fell between the ages of 15-29.

Rates of sexually transmitted diseases have dropped dramatically over the past five years in Mississippi. Rates for early syphilis decreased from 163.82 per 100,000 population in 1994 to 27.21 per 100,000 in 1998. In 1994, the rate of positive HIV screens (ages 13 and above) was 22.41 per 100,000 population; in 1995, 22.59; in 1996, 21.54; in 1997, 20.72; and in 1998, 19.76. As of December 31, 1998, 3,545 confirmed AIDS cases and 5,835 HIV infections among men and women aged 13 and above have been reported to the state health department. In 1998, there were 35 women who tested HIV positive; 60 women aged 20-29; and 108 women aged 30 or over who were newly diagnosed as HIV positive.

In 1999, the rate of positive HIV screens was 18.53 per 100,000. As of December 31, 1999, 3,927 confirmed AIDS cases and 6,324 HIV infections among adolescent or adult men and women have been reported to the state health department. In 1999, 28 women 13-19 years old; 63 women ages 20-29, and 102 women ages 30 and over were newly diagnosed as HIV positive.

Conclusions:
Mississippi continues to experience too many unwanted and poorly timed pregnancies. Sexual activity is beginning at too young an age and STDs are a major problem which may be contributing to LBW and the IMR. There is a need and Mississippi will seek additional ways to integrate STD services into the MCH program. Because the STD program is physically separated from the MCH programs, coordination of screening and treatment services must be negotiated and discussed on a regular basis.

Health Care Access
Many, but not all, of Mississippi's maternal and child health problems might be decreased by improving health care access. But improving access is costly and, as has been shown, Mississippi is a poor state. Given the funds available, priority-setting becomes a major task. However, access to health care is not the only way to improve health status in the state. Health promotion and education efforts in schools and communities, and enactment and enforcement of health-related laws and regulation, for example those ensuring child safety or dealing with domestic violence, would also improve health status.

Several types of access barriers will be considered. Financial barriers are perhaps the most important, but the availability of services and their acceptability are also considerations.

Financial Access to Care
The lack of health insurance makes it difficult for many Mississippi women and children to access health care. According to a 1998 publication by The Urban Institute, Medicaid is currently the only health insurance program for low-income families in Mississippi. The maximum eligibility for receipt of Medicaid in Mississippi is 24 percent of the federal poverty

level (FPL)-lower than the national average of 39 percent of the FPL, but higher than a number of its neighboring southern states. Even with its narrow eligibility, Mississippi has a relatively high participation rate; 16 percent of all state residents rely on Medicaid for health care coverage.

Mississippi is currently taking advantage of the opportunity to enhance its Medicaid program by expanding health care coverage to the uninsured, especially children. The **Infant Survival Program** provides Medicaid benefits to infants up to age one and pregnant women with family income not exceeding 185 percent of the Federal Poverty Level. As of June 1999, 10,764 infants up to age one and pregnant women were eligible for these benefits. **Expanded Medicaid** provides Medicaid benefits to children up to age six and pregnant women with family income not exceeding 133 percent of the Federal Poverty Level. As of June 1999, 25,544 children and pregnant women were eligible for these benefits. **Poverty Level Medicaid** provides Medicaid services for children born after September 30, 1983, with family income not exceeding 100 percent of the Federal Poverty Level. Phase I of the **Children's Health Insurance Program (CHIP)** was implemented July 1, 1998, and covers children up to age 19 in families whose income does not exceed the 100 percent Federal Poverty Level. As of June 1999, 115,536 children up to age 19 were eligible for these benefits. **Medical Assistance** provides Medicaid benefits to families with children under age 18 and pregnant women who meet the pre-reform AFDC need and deprivation standards. Extended Medicaid is also provided for twelve more months to TANF families who lose Medicaid because of increased earnings. As of June 1999, 17,358 children up to age 18 and pregnant women were eligible to receive benefits.

According to a June, 2000 publication by Health Advocacy News, a Mississippi Health Benefits Outreach and Enrollment Plan, which includes a $250,000 media blitz, has been initiated by the Governor to create public awareness around the availability of health insurance coverage for uninsured children in Mississippi. As a result of the Governor's concern over the low enrollment in the Children's Health Insurance Program (CHIP), he has created an interagency task force to help address the problem. As of January, 2000, approximately 7,000 children were enrolled in the CHIP program.

Some families in Mississippi require assistance to address serious and immediate needs that move beyond financial supports. Child welfare services and emergency assistance are part of the state safety net that serves families who face internal strife or who are unable to meet such basic needs as food and shelter.

In recent years, the Department of Human Services (DHS), in Mississippi has been proactive in its reform of child welfare services, emphasizing family preservation and reunification. This emphasis has begun to foster an increased partnership between DHS and community providers, which will prove important in addressing the challenges of a system in transition.

According to the Mississippi Department of Human Services Annual Report for SFY 1999, Mississippi continues to be one of the leading states in designing and implementing welfare reform programs as evidenced by the significant decrease in TANF caseload because families are employed. The TANF state plan supports the goal of providing care to the truly needy while giving people the opportunity, through employment and transitional benefits, Medicaid and child care assistance to make the change from welfare to work. No longer is this public assistance program considered an entitlement program but is intended instead to:

- Provide temporary assistance so that children may be cared for in their own homes or in the homes of relatives;
- End dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals of preventing and reducing the incidence of these pregnancies;
- Encourage the formation and maintenance of two-parent families; and
- Prevent program fraud and abuse.

Eligibility for the TANF program is determined for families with children under age 18 who are deprived of parental support because of absence, incapacity or unemployment and is based on income and resources. Maximum monthly TANF benefit levels are $60 fo rthe first person, $36 for the second, and $24 for each additional person in the unit. The Governor approved 1999 Legislative amendment to increase the first person's benefit maximum form $60 to $110 made effective July 1, 1999.

Because of the critical need for reliable transportation for participation in the TANF Work Program and for retention of employment, the TANF resource limit was increased in February 1999 from $1000 cash value to $2000, and the value of one vehicle per family became totally included. A second vehicle would be compared to the ongoing Food Stamp Program vehicle value exclusion, up to $4650 fair market value.

As a condition of eligibility, the adult in the TANF case must assign rights of child support to the state and cooperate with child support enforcement. In addition, each able-bodied adult must participate in the TANF Work Program (TWP), unless specifically exempt. Incentives to encourage the participant to move quickly into employment include a six-month total earnings disregard for persons who find full-time employment within 30 days of initial approval for TANF or within 30 days of beginning the job readiness activity. For TWP participants who do not receive six-month disregard, there is a three-month disregard of earnings for families whose TANF case will terminate because of increased earnings. Failure without good cause to participate in an approved work activity causes a full TANF benefit sanction. The sanction period for the first work-related violation is two months, six

months for the second violation and twelve months for the third violation. There is also a

comparable disqualification for food stamp recipients who do not meet work requirements.

Full-time employment and job retention is the centerpiece of the TANF Work Program, which allows a range of work activities to count toward federally mandated participation rates. Allowable work activities include job readiness training, unsubsidized and subsidized employment, community service and work experience, education, on-the-job training, and job skills training directly related to employment. TWP participants are provided transportation and child care assistance to enable them to attend work activities, look for employment, and go to and from work. The TANF family who loses eligibility for cash benefits because of earnings is eligible for transitional child care and up to nine more months of transitional transportation assistance.

The TANF Program includes the family benefit cap provision, which prohibits the increase of cash assistance for children born into the recipient family after ten months of benefits. The program also include school attendance and immunizations requirements. Families with children who do not satisfactorily attend school or who do not have current immunizations have their money payment reduced by 25 percent per month until compliance. If a sanctioned family receives food stamps, a 25 percent reduction is also applied to that benefit.

In addition to the TANF Program, the Department of Human Services's Division of Economic Assistance (DEA) determines eligibility for the Division of Medicaid for selected Medicaid Programs including Infant Survival, Expanded Medicaid, Poverty Level, and Medical Assistance for children, families and pregnant women. Families eligible for TANF are also eligible for Medicaid based on a common standard of need, and extended (transitional) Medicaid is provided for 12 months after the TANF family loses money payment because of increased earnings.

Availability of Care

Mississippi has a shortage of health care providers and of health care facilities for women and children. Of the 2,158 primary care physicians in the state, there are 669 family practitioners, 177 general practitioners, and 333 OB/GYN physicians. Of these, 48 percent are aged 60 and older and may have limited practices. Mississippi as a whole has a primary care physician to population ratio of 1:1,310. As of June 16, 1999, 63 areas in the state were designated as Health Professional Shortage Areas (HPSAs) and were eligible for National Health Service Corps practitioners to help provide service. At that time, the MSDH Primary Care Development Program estimated that it would require 111 professionals to remove the HPSA designations. Nursing manpower is also in short supply. Of the 21,294 registered nurses employed in nursing careers, only 4,757 (19.6 percent) work in community health.

Mississippi has 21 community health centers, serving patients at over 40 clinics throughout the State. More than half of these clinics provide perinatal care, and family planning

services. The Coastal Family Health Center in Gulfport, Mississippi, Jackson-Hinds Comprehensive Center in Jackson, Mississippi, and the Family Health Center in Laurel, Mississippi provide full perinatal care, including deliveries by staff obstetricians. Many centers provide uncomplicated care using family practitioners for their low risk patients, referring high risk patients and deliveries to obstetricians.

Many hospitals in Mississippi accept clients requiring hospitalization for reproductive health problems, but the number of institutions are shrinking. Fifty-four hospitals reported that they provide perinatal services in 1998.

One result of the personnel shortages is increased demand for services at health department clinics and community health centers which generally operate only during daytime hours, although a few have expanded hours to meet the need. As a result, women and children must often wait for a long time before they receive an appointment for some services. This causes problems particularly in regard to family planning services. Women and children may also have to wait for many hours in a clinic site before they receive care, although some services have been streamlined, such as the “fast lane” for immunizations.

The MSDH, through its state Title V agency, is a major provider of health services to poor and near-poor women and children in Mississippi. While other organizations such as community health centers, rural health clinics, and hospitals have assumed some responsibility for the poor and near-poor, the MSDH serves the largest number and is the agency of last resort. The MSDH network of district and county health departments provides a range of clinical and educational preventive services and the Children's Medical Program cares for many children with special health care needs at sites throughout the state. There may not be enough staff to ensure that all those who seek care receive it promptly, but the infrastructure is present.

Mississippi has relied on non-state sources to supplement its health department clinic network. There are 21 Federally Qualified Community Health Centers in the state and 135 rural health clinics under private auspices that provide care to women and children. The opening of these rural health clinics contributed to the reduction of the number of pregnant women being seen in local health department clinics. The rural health clinics and CHC's are not on the PIMS data system so no data are available about the number of women and children served. The MSDH monitors those clinics that are independent WIC certifiers and family planning contractors.

The MSDH Primary Care Development Program, as of March 16, 2000, had 17 active National Health Service Corps placements: one internists, four family practitioners, one pediatrician, and one psychiatrist. Also serving were five dentists, and five nurse practitioners. The Primary Care Development Program has also placed 23 foreign physicians on J-1 visas in underserved areas. Not all are in practices that accept Medicaid clients.

Few clinical and educational services are addressed to children and adolescents. Few health department clinics see sick children or well or sick adolescents, although many community health centers and Rural Health Clinics do.

Currently, there are 24 school-based clinics in Mississippi. As of October 5, 1999, two additional clinics in McComb, Mississippi were proposed but are presently non-operational, and two other school-based clinics were projected to open by January, 2000.

Other Access Issues

The lack of public transportation contributes to the difficulties many poor people encounter in obtaining care. Urban transit systems serve only the Jackson, Hattiesburg, and the Biloxi/Gulfport areas, where taxi service is also available. Rural transit systems consist of elderly/handicapped buses operated by a variety of community agencies, for example, the Choctaw Transit Authority; Lift, Inc. in the Tupelo area; and Five County Child Development (Head Start). In addition, the MSDH arranges transportation for some patients. Ambulance transport of high risk mothers to the most appropriate site is paid by Medicaid while the MCH Block Grant supports the infant transport system at UMC.

Title 504 of the Civil Rights Bill requires hospitals to have interpreters available. The county health department and the community health centers offer maternal and child health services to the Vietnamese population concentrated in the coastal area of the state, including CSHCN related services. Health education materials for family planning, prenatal and immunizations are available in Vietnamese and Spanish as well as English. Translation services are available through an ATT service. The Catholic Charities coastal office has a Vietnamese Resettlement Program with two interpreters and contracted services in the community. In addition, Mississippi's Band of Choctaw Indians has identified an interpreter who is available upon request. The ATT service also assists the recent influx of migrant or undocumented women and children whose first language is Spanish or almost any other language.

Another approach to increasing availability of services is HealthMACS, the Mississippi Medicaid managed care system introduced in 1993, now in place statewide. Under HealthMACs, the Medicaid recipient selects a primary care provider (or one is selected for her) to provide, through an on-going relationship, primary care services and referral for all necessary specialty services. The primary care provider (PCP) is responsible for monitoring the health care and utilization of non-emergency services. Emergency services, case management (Perinatal High Risk Management), CSHCN and family planning services are exempt, therefore not requiring PCP prior approval. HealthMACs covers those recipients that are eligible for AFDC or AFDC related services, i.e. EPSDT, maternity, well and sick child services, etc. Due to the implementation of HealthMACs, there has been a significant decrease in the number of maternity clients and children seen in county health department clinics. This change has made more staff available to provide more enabling services such as case management and home visiting. However, the low Medicaid reimbursement is causing

some HealthMACS physicians to refer children to county health department clinics for primary care, especially EPSDT screens. If a referable problem is uncovered, the children must return to the HealthMACS physicians for another examination prior to treatment. Such an arrangement increases costs, creates delays, and probably leads to families not following through.

Conclusions:
Health care for women and children is not readily available in Mississippi. This review of access to health care in Mississippi suggests some of the reasons for the state's low ranking on maternal and child health status indicators. Client financial problems are compounded by insufficient numbers of health personnel who are not distributed in terms of population needs; an inadequate number of facilities, not user-friendly and not equitably distributed; and the absence of a public transportation system or a transportation system adequate for health care needs. While the MSDH and other state agencies, particularly Medicaid, have taken major steps to ameliorate these problems, the situation is still serious. Other problems that must be addressed are unwanted and mistimed pregnancies, births to teens, prevention of maternal substance abuse, and tracking of high risk mothers and their infants.

Delivery Systems
As noted in other places in this application, the Office of Personal Health Services (OPHS), within the MSDH, is one of the major providers of primary care services and specialized care to the poor and near-poor residents of Mississippi. Its services encompass prenatal care including WIC, services for children and adolescents including immunization and preventive and restorative services for CSHCN, and reproductive health services including family planning. While other organizations such as community health centers, rural health clinics, and hospitals have assumed more responsibility for the poor and near-poor, the MSDH, and particularly the OPHS, is the agency of last resort and the primary provider of care through a network of district and county level health departments that provide a range of primary and preventive services, and through the Children's Medical Program which cares for many children with special health care needs at sites throughout the state.

The OPHS staff is aware of the need to work with state government and non-governmental agencies to expand services and to provide leadership and oversight as new programs are developed. However, limited staff has prohibited major efforts in these areas.

3.2.2.2 Direct and Enabling Services
3.2.2.3

Women's Health

The MSDH, through its county health department system provided over thirty percent of the prenatal care to women who gave birth in Calendar Year 1998. In some districts, maternity clients are seen in county health department clinics until they receive their Medicaid cards. In other districts clients are seen in the private sector as soon as pregnancy is confirmed regardless of their Medicaid status. Some county health departments contract with private providers to provide prenatal, postpartum, and family planning services within the health department clinics. All 82 counties are PHRM/ISS providers. In FY 1999, case management services were provided to over 9,000 high risk mothers and infants. Mothers and infants that are not high risk and are Medicaid eligible, receive at least one postpartum home visit following delivery. In some districts, Medicaid eligible mothers and infants receive a visit in the hospital prior to discharge to certify for WIC and to assess their eligibility for CMP and Infant and Toddler Services. Family planning services are provided through local county health department clinics, and through contracting with community health clinics, Job Corps, and university/college health centers. More than 97,000 Mississippians, 30,867 of them 20 years of age or younger, took advantage of comprehensive family planning services during CY 1999. Abnormal pap follow-up is provided in-house in five of the nine public health districts by trained colposcopists. In the other four districts, colposcopic services are provided by private providers.

Direct and Enabling Services

Infants

As with children and adolescents, the majority of services provided to infants in the Department of Health are 1) EPSDT referred by Medicaid HealthMAC primary care providers, 2) PHRM for high risk infants, 3) Postpartum home visiting to non-PHRM infants, and 4) direct clinical services through genetic, sickle cell and CMP clinics. Acute pediatric care is provided in areas where primary pediatric care shortages are most severe. The birth to three population in need of early intervention services is also screened and followed through the local county health departments.

One district stated that they are working with programs such as Parents as Teachers and Families First which are offering services to pregnant teens and mothers with young infants.

WIC certification is provided by county health departments and independent agencies with which the Bureau of WIC contracts. Breast-feeding is encouraged. Mississippi is the only state that has distribution centers rather than using vouchers. WIC services are available in all counties.

First Steps: Mississippi's Early Intervention Program for Infants and Toddlers is available in all public health districts. First Steps is an interagency system designed to coordinate services necessary to prevent and/or minimize the effects of disability on young children (birth to third birthday) with special health/developmental needs and their families. As the lead agency for

First Steps, MSDH serves as the single point of intake for the early intervention system.

Special Populations

Many districts are seeing a growing number of Hispanic infants born to un-documented mothers. These infants present a growing concern to the staff at the local level. Even though these infant are Medicaid eligible, the parents do not seek Medicaid enrollment due to the fear of deportation. Other sub-populations include the Amish, who do not seek traditional medical care, and foreign students at colleges and universities. District V-Jackson Metropolitan Area has a Hispanic population of about 16percent and an Asian population of about 16percent. This same district states that there are 48,203 children under 18 years of age who live in poverty; Hinds county has 22,283 and other counties range from 285 to 3,500.

The Choctaw Tribe has its heaviest population in two counties in the East Central Public Health District . The tribe has their own health care facility, however, sick infants (most on Medicaid) are often taken to local emergency rooms for care.

Direct and Enabling Services

Child and Adolescent Health

The majority of direct services provided to children and adolescents within the Health Department setting are EPSDT screening, subcontracted from Medicaid HealthMac primary care providers, PHRM/ISS Postpartum home visits to pregnant and parenting adolescents, and direct clinical services through genetic, sickle cell and CMP clinics. Acute pediatric care is provided in areas where primary pediatric care shortages are most severe.

As previously stated, 18.9percent of children less than 18 in Mississippi live in poverty. In some counties within the districts, the percentage of children living in poverty exceeds 20 percent. According to latest national data, the median family income for a family of four was $37,328 (1995) compared to $49,681 in other areas of the country (and which is very close to the 200percentf FPL for a family of five). The average minimum rent for a minimum wage earner is 45 percent of monthly salary, leaving little for insurance premiums.

Uninsured children are estimated at 90, 000, roughly 20percent of the population. Child Health Insurance Outreach, a major initiative of the health department, primary care providers, and child advocates, is aimed at enrolling as many uninsured children as possible. In some areas, with severe pediatrician shortage and decreased participation of pediatricians and pediatric dentists in Medicaid, it is questionable whether increased enrollment will have the expected benefit of increased access. In other areas of the state, clinicians are anticipating an improvement in the health status of children who can now afford preventive care services, an increase in the number of children who establish a medical home, and reimbursement for

acute services previously provided without fees. It is expected that CHIP outreach will expand Medicaid rolls and reinstate many of the children whose benefits were lost secondary to welfare reform.

Children of diverse cultural and ethnic groups in Mississippi face several challenges in accessing health care. Hispanic children born in the state have not enrolled in Medicaid secondary to parental fears of deportation. Older Hispanic children and teens who are illegal immigrants have no options for health care insurance coverage. Health departments, community health centers, emergency departments, Catholic Charities and Methodist outreach ministries, and some teaching hospitals provide gap-filling services for these young clients. Resources for other than routine care is limited in the majority of health department clinics. There is an increased need for Spanish speaking interpreters, Spanish literature, and understanding of cultural differences by health care providers. Cultural sensitivity remains an issue in dealing with ethnic populations in general. Provision of services to subgroups such as the Amish who do not rely on traditional medical resources will require innovative strategies.

Eighty-two counties in Mississippi are designated all/part medically underserved area (1996 HRSA). Sixty-three of eighty-two counties are designated all/part health professional shortage areas. Children in many counties lack access to general pediatric care. As critical, however, is the need for access to pediatric subspecialty care, especially for children with special health care needs. Increased local assessments are needed as well as transportation to regional centers. Transportation was listed as a major barrier by communities and providers of care. It was specifically cited as a barrier to families of children with special health care needs. The addition of local clinics and provision of transportation are seen as remedies to increase accessibility to appropriate health care.

For services provided by health department clinics, increased collaboration of private primary care providers and public providers is essential to decrease fragmentation of care. Coordination of standards of care for routine health maintenance with standards for WIC, EPSDT screening, lead screening and follow-up, Emergency Medical Services for Children (EMS-C) programs, and school safety should improve the general health status and impact the accidental death rate.

The systematic addition of oral health education, including oral hygiene and the use of dental sealants during anticipatory guidance is essential. The Mississippi State Department of Health (MSDH) has entered into a contract with Dr. Stephen L. Silberman and the University of Mississippi School of Dentistry to screen third grade public school grade students in each of Mississippi's nine public health districts. A stratified sample of schools will be selected using the criteria outlined below. Data will be collected utilizing an Oral Health Screening Form for School Children developed by the Association of State and Territorial Dental Directors. Background information collected on each student will include the screening date, school code, screener's unique identification number (ID), student's unique ID, birthrate,

age, gender, and race. To ensure that this study has the highest probability of providing accurate answers to the questions, the following criteria will be employed:

- all nine public health districts will be included in the sample,
- schools will be the sampling unit,
- schools to be chosen will be representative for the size of the school as well as the community it represents,
- the sample will be drawn randomly from each public health district and randomly within each district to account for school size,
- investigators will be standardized regarding procedure to be followed and data to be collected and calibrated to account for interrater and intrarater reliability.

A stratified random sample has been drawn to include approximately 5400 students in 75 schools throughout the nine public health districts in Mississippi. The proposed sample will provide accurate answers to the questions posed with an error margin of ±5percent. Data collected during this project will serve as baseline data for future comparisons.

Direct and Enabling Services

Children With Special Health Care Needs

The Children's Medical Program (CMP) conducted surveys of parents of children with special health care needs at the 1999 Building Partnerships Conference, as well as various Children's Medical Program Clinics in four State Department of Health Districts. Survey respondents included eighty five parents, grandparents, and guardians of children with special health care needs. This survey population came from thirty-three different counties and represented all nine public health districts in the state.

In summary, racial breakdown reflected that fifty-seven percent of the respondents were black, forty-three percent were white. Two of the respondents reported that their child with disability is Hispanic. Seventy-nine percent reported that their child with disabilities has a local doctor or nurse practitioner, who provides ongoing medical and well-child care. This is particularly an important concern for MSDH as there is a performance measure related to medical homes and are concerned that every child with special health care needs has a medical home. Medical services for children with disabilities were paid for by various sources including Medicaid, private insurance, SSI, Children's Medical Program and family resources. Eighty percent of the survey respondents noted that their child was covered by Medicaid. Thirty-two percent stated that private insurance paid for their child's care, eighty percent said Medicaid, twenty-five percent SSI, twenty-four percent family resources, and forty percent said that CMP covered the services. It should be noted that some children do have more than one source of coverage for which medical services could be paid. Some of

the children actually may be covered by up to four of these various resources.

The survey respondents identified problems and unmet needs. The survey allowed respondents to choose more than one answer. The number one concern identified was school concerns. This was identified by forty percent of respondents. Thirty-two percent identified childcare as a concern. Thirty-one percent identified family support issues as a concern. Twenty-nine percent identified finances as a concern and eighteen percent expressed concerns regarding the health care system complexity when addressing their children's special health care needs. Other problems and unmet needs identified were behavior of their child with disabilities; a shortage of pediatric sub-specialists; lack of enforcement of the American with Disabilities Act and Individuals with Disabilities Education Act; the need for job training for children with special health care needs; need for speech therapists; and the need for dental care for children with special health care needs.

The Children's Medial Program distributed surveys to members of the Professional Advisory Committee to obtain their assessment of the problems faced by the families of children with special health care needs. This involved mailing questionnaires to sixteen providers. Ten were returned completed. Sub-specialists responding to the survey included three pediatric orthopaedic surgeons, one pediatric urologist, one pediatrician, one otolaryngologist, one orthodontist, two plastic surgeons and one pediatric dentist. In response to the question regarding the most pressing need for Children's Medical Program patients that you (the provider) see are listed below in order of importance:

1. Patient transportation
2. Money for medical care and other services
3. School concerns related to the child with disabilities
4. Dental care for children with disabilities
5. A network of medical services that is easier to understand

Respondents were asked to report any problem regarding the CMP in general. The number one problem reported was the CMP reimbursement rate. Several providers felt that the CMP reimbursement rate should be adjusted upward. Also reported as a problem was the procedure for the provider to receive payment from CMP. The primary complaint was that this involved too much paperwork, and the only other problem reported was that some providers felt like that more diagnoses should be open to coverage by the CMP. Although the CMP covers a wide array of diagnoses and receives annually requests to cover more diagnoses, the ability to increase diagnoses coverage is limited to the availability of funds.

In an effort to address the need for improved access to dental care, the Children's Medical Program covers dental aids and orthodontic services related to craniofacial defects. The Mississippi State Department of Health's Dental Program provides some assistance. There is a need for more dental providers who accept Medicaid and who see children with special health care needs. Addressing this need will involve some effort with the community and

rural health centers, who should have dental services available through each of their clinics.

CMP's effort to address the need to strengthen and formalize a continuum of care (newborn to adult), will include the involvement of the State Department of Education, rehabilitation services, universities and colleges, and others. This effort would incorporate the already established transition program. This will also involve improving communication with primary care providers and community service providers for both medical home and community resource involvement. The CMP plans to employ a parent of a child with special health care needs to help facilitate input and to serve as a parent consultant to the program.

Plans are presently in effect to expand the current focused case management effort and care coordination activities of the Children's Medical Program. The development of case management services will be evaluated to compare a Centralized Case Management System versus a Regionalized Case Management System. Case management efforts will include children with special health care needs, not only those enrolled in the CMP, but those not enroll if requested by the family.

There is a documented shortage of pediatric sub-speciality providers in the state. For example, there is a limited number of Board Certified Pediatric Neurosurgeons, Pediatric Urologists, Pediatric Orthopaedic Surgeons, etc. Because specialty providers are located primarily in urban areas, we cannot expect sub-specialty providers to be available and/or near every community. A regionalized approach may be needed to address this issue. This issue bears further exploration and evaluation with input from the sub-specialty provider community. This effort will involve collaboration with Medicaid on strategies to increase provider participation with Medicaid. It should be noted that Medicaid recently increased it rates, but some areas are still lacking, i.e., in dental services and anesthesia.

CMP now pays some travel assistance to families. Medicaid provides transportation, but this transportation must be arranged one week in advance. This requirement does put a burden on some families who are having a difficult time scheduling transportation around work, childcare providers, and children with special health care needs doctor appointments. Those families with a child who is not covered by Medicaid generally lack transportation resources. The primary feedback received on this issue is that not enough childcare facilities accept children with special health care needs. There are respite programs that do exist, but reimbursement may be low or inadequate. For respite, Medicaid Home and Community-Based Waiver is open to mentally retarded individuals only.

Gaps in Service

Some of the gaps in services cited by the districts for infants are the same for women, i.e., transportation and lack of high risk providers. Children with special health care needs sometimes have to travel long distances to receive services of pediatric sub-specialists.

Lack of dental services for children on Medicaid is a serious problem in the state. Most

dentists in the state do not accept Medicaid. One district stated that there are two pediatric dentists in the eleven county district; one does not accept Medicaid and the other takes Medicaid on a very limited basis.

One district has pediatricians in only four of their ten counties. Limited childcare is available for low income families and childcare for newborns is limited for mothers in drug treatment. Few services are available for infants born drug addicted. It is difficult to obtain healthcare for uninsured infants in a timely manner. One district reported that in one of their counties, pediatricians refuse to see sick children on Medicaid. Districts also report a lack of assistance with primary care for infants. One district noted that the emergency rooms are still consistently used for sick child care.

3.2.2.4 Population-Based Services

Women's Health

SIDS- The Bureau of Women's Health receives all matched birth and death certificates of infants. These are sent to the district SIDS Coordinators and then distributed to the county staff for follow-up. The parent/s are contacted regarding a home visit and/or referral to a support group. The Bureau is in the process of reviewing the SIDS Program. A survey of the nine public health districts was conducted and the results are included below:

- all districts have some type of home visiting activities following a SIDS death;
- 3 of the 9 districts said public health nurses provides the home visit and 7 of nine districts stated social workers provided the home visit (1 district both disciplines provide home visits);
- 2 of the 9 districts indicated that it would take more staff for them to begin providing home visits to all SIDS families, 1 of 9 districts stated they would need travel funds, 2 of 9 districts needed staff training and 1 of 9 districts stated death certificates needed to be received in a more timely manner;
- when surveyed related to staff training needs, 5 districts needed training on how to conduct a SIDS interview, 6 districts wanted training on grief counseling, 3 on cultural competency, and 7 on the epidemiology of SIDS.

There is also a SIDS Coalition composed of private providers, representative from the coroner's association, law enforcement, MSDH staff, day care licensure staff and others. Presently the coalition is working on a survey for new parents to access their knowledge related to reducing the risk of SIDS. These data should be analyzed by the end of CY 2000.

The FIMR Project began in six counties in District I and now has expanded into two counties

into District III. The project is completing its third year of funding through the Maternal and Child Health Bureau. The plans for the projects is to expand statewide. In a couple of the districts, the local delivering hospitals conduct infant death conferences. In those districts, it would benefit both the agency and the delivering hospitals to partner and do the conferences jointly. The biostatistician with the project is currently working on revising the national FIMR data collection tool to make it more Mississippi appropriate.

Maternal Mortality Review
The Bureau of Women's Health is presently reviewing the process for reviewing maternal deaths along with the MCH Epidemiologist. The Bureau is in the process of evaluating several data collection tools to determine which would be more appropriate for our needs with some revisions. The Mississippi State Medical Association continues to review all maternal deaths that occurred within a five year period. The intent of the MSDH is to gather more in-depth information on these deaths and share this information with the Medical Association. One of the barriers the staff has encountered as they are attempting to gather data from the hospitals and private providers is their reluctance to share information because of their fear of litigation.

Population-Based Services

Infants

SIDS-see previous section on Women's Health

FIMR-see previous section on Women's Health

Newborn Screening -The newborn screening program includes testing for phenylketonuria (PKU), hypothyroidism, hemoglobinopathies, and galactosemia. With more than 40,000 newborns delivered in Mississippi each year, it is expected that approximately four PKU, ten hypothyroid cases, sixty hemoglobinopathy cases (mostly Sickle Cell diseases), and maybe one galactocemia case will be identified annually. Early identification and follow up of these genetic disorders allow for prompt initiation of interventions to prevent permanent damage and optimum health status.

Initial newborn screening takes place in the delivering hospital. The health department will occasionally have to perform the initial screen on an infant who leaves the hospital prior to the screen being done or who is born outside the hospital setting. All reports are sent to the Genetics Program. The Genetics Program office notifies the resident county health department, the hospital of birth, the clinician listed on the lab slip, and in most cases, the Genetics Field staff by telephone of any positive screening results. The health department is requested to locate the infant and family immediately so that confirmation can be initiated. The report of the confirmatory test results along with specific instructions for management is sent to the county health department.

Immunization -Immunizations are provided in all county health department clinics. Adequate and timely immunizations for all infants and children is a priority of the MSDH. The MSDH guidelines for vaccine administration were developed to ensure accurate administration of vaccines with the assurance that all children will be age appropriately immunized according to current ACIP recommendations. No child will be denied routine childhood vaccine at a MSDH clinic, regardless of Vaccines for Children (VFC) eligibility category or ability to pay an administration fee. It is stressed that each clinic visit should be looked upon as an opportunity to review and update a child's immunization status. If children less than or equal to two years of age or their parents are in a clinic for any reason, the immunization status of the child/children should be evaluated by reviewing the child's health record or computer history. If immunizations are needed, they should be administered without appointment, physical exam, or referral.

The MSDH participates in the Vaccine for Children's Program. The MSDH supplies vaccine at no cost to physicians and other providers who agree to participate. The vaccines, singularly or in conjunction, offered through the VFC program are those providing protection against 12 diseases: diphtheria, Haemophilus Influenza type b, hepatitis B, poliomyelitis, measles, mumps, rubella, pertussis, varicella, tetanus, pneumococcal disease and influenza.

LEAD SCREENING-see following section on Child and Adolescent Health

Injury Prevention -The car seat distribution program is managed by the Injury Prevention Coordinator in the Division of Health Promotion and Education and implemented by district and county health department staff. Parents are taught how to correctly install infant car seats and how to properly restrain infant in seats. Mississippi law requires that children under the age of four, being transported in a motor vehicle, be properly restrained in a child restraint device and that all front passengers in a motor vehicle wear a seat belt. During EPSDT and well child visits, parents are provided age appropriate developmental and safety counseling.

Population-Based Services

Child and Adolescent Health

Newborn genetic screening program effectively reaches infants born in hospitals and has an outreach program designed to serve those outborn as well, thus facilitating medical intervention for those identified with genetic or congenital disorders. The Birth Defects Registry, by collecting data on congenital anomalies, allows for better categorization and

foster early identification and intervention, subsequently decreasing associated morbidity and mortality.

Lead Screening rates have decreased in proportion to the number of children directly served within health department clinics. Efforts to encourage private sector screening of at-risk children continues. The State Lead Advisory Committee attests to public and private collaboration in this area. The need for temporary lead-free housing remains a challenge as does state-wide surveillance.

Immunization Current rates are very close to the Year 2000 goal. Diligence in immunization, facilitation of good relationships with primary care providers, institution of CHIP Vaccine Program, expansion of barcoding program, and expansion of Internet capabilities are necessary to boost these rates.

Population Based Services

Children with Special Heath Care Needs

According to survey respondents, there is a need for enhanced pediatric mental and behavioral health services. There are not enough resources based in the community, either outpatient or inpatient to achieve ready access to the service for all of those in need. The CMP plan to work with the Department of Mental Health regarding this accessibility issue. Addressing this issue might also involve exploring some type of pilot program within the Children' Medical Program to improve access to care.

3.2.2.5 Infrastructure Building Services

Women's Health

In an effort to assist clients in getting needed services, much collaboration between agencies, providers and hospitals has taken place. Many districts have interagency councils or committees that help to identify problems and seek solutions. Several districts have local infant death conferences at delivering hospitals.

Counties and districts have partnered with private providers to enhance their awareness of non-traditional services provided by the MSDH such as postpartum home visiting and postpartum hospital visiting. Most agencies and providers know that family planning services are available through the MSDH at no cost or on a sliding fee scale to eligible women and are good referral sources.

Some districts have developed partnerships with non-traditional partners such as local

housing authorities and colleges. One district has established collaboration between the school systems, hospitals, county extension service, March of Dimes, Red Cross, and others to provide educational opportunities for women, children, and adolescents within the nine county area.

One district stated that the primary asset in their district is the collaboration which has been established between the community health centers, the area hospitals, and the private medical community. They have developed an innovative system of OB care in response to Medicaid managed care. The system was established to assure continuity of patient care related to prenatal services, "wrap around services" such as WIC, PHRM, and postpartum home visits to Medicaid recipients, as well as referral for delivery. One county in this district is actively involved in an "Alive Jones County" project in Laurel with the local regional medical center and other community leaders to assess and implement community projects based on a needs assessment.

All nine district offices reported that the clinics in their districts conducted consumer satisfaction surveys. Results of the survey indicated that overall, the clients are basically satisfied with clinic services provided by county health departments. One hospital in the Delta conducted a community survey that looked at health risks, health coverage, barriers to obtaining care, preventive health care, children's health, and lifestyle choices. The goal was to provide an in-depth understanding of the health care needs and preferences of area residents. Focus groups included community leaders, medical professionals, employers, and consumers. Overall findings were somewhat satisfied.

The Community Health Advisory Network (CHAN) in the Delta Hills Public Health District, convened a special focus group to gather information about community needs in general in the District III service area. The focus group was held in December 1999 and was attended by twelve CHAN members and local government officials. Questions focused on the specific needs of children, infants, women and adolescents in the Sidon community and surrounding areas as seen from a community-wide perspective. This district also did a special survey in Washington County of parents of children utilizing MSDH services . The survey focused specifically on the unmet needs of this group. The results of the survey indicated that 84percent of the respondents were African-American; 53percent of the children had a local doctor who provided their care; 73percent had Medicaid; 10percent had private insurance; 89percent of the mothers were not familiar with M-CHIP.

Some of the unmet needs as voiced by the respondents in the surveys included:

- Long waiting times
- Delays in obtaining appointments
- After hours and weekend services
- More privacy at front counters
- More educational material while waiting
- More staff

- Need for better educational opportunities
- Need for improved levels of adequate housing
- Assistance with controlling the growing presence of alcohol and drugs in the community/drug programs/treatment centers
- Need for more job opportunities
- Need for better health care and more accessible health care
- Need for better communication between all members of the community
- Need for additional assistance in controlling teen pregnancy
- Need for additional assistance in controlling STD/HIV
- Need for community wide curfew
- Person in warehouse need better attitude
- Need different place to get service for WIC if not being certified
- Need to make appointments for everyone in family on same day
- Deliver WIC package/WIC for seniors
- Need transportation to get to medical appointments
- Free or reduced rate health care/non-profit clinics for all women/non-profit clinics for indigent children
- Teen centers/services/after school programs/public/private youth programs
- Child/daycare services
- Parenting programs
- Nutritional education programs
- Changes need to be made in the facility/ waiting room/lobby/need baby changing stations
- Need more time to talk to physicians
- More information on pregnancy/infant care/parenting
- Understanding where to go for what services

Special Sub-Populations

The ethnic and racial makeup of Mississippi is rapidly changing. Many districts report a growing Hispanic population related to the poultry, farming and forestry industries. The majority of Hispanic clients seen in county health department clinics are in the childbearing age and are undocumented. They are usually pregnant or seeking family planning services. Because they are undocumented, they do not quality for medicaid benefits except emergency medicaid which covers delivery ONLY. Many refuse to apply for emergency medicaid because they fear being reported to immigration services. Because of the fear of being reported, the parents do not follow through and apply for medicaid for the newborn who is a United States citizen and would qualify for medicaid. This places an especially difficult hardship on county staff trying to access services for this population because of the financial and language barriers. In an effort to reduce the language barrier, several districts have hired translators through special grants such as Title X Special Initiatives. Some districts have staff that speak Spanish as a second language already on staff, and some counties use community volunteers as interpreters. Because these women have no medicaid or insurance, private

providers and hospitals are reluctant to see them. Many have to travel to Jackson for high risk and delivery services. Some appear at the local hospital in labor thus forcing the hospital to see them.

The Choctaw population is concentrated in one of the nine public health districts. Services to this population are largely provided on the reservation by Indian Health Services. Most of the deliveries take place at the University of Mississippi Medical Center in Jackson. The agency continues to try and collaborate with this population in the provision of services, but this is sometimes difficult. The Choctaw Health Center has developed an effective clinic for women and children coordinating with the University of Mississippi Medical Center to handle their high risk patients.

Several districts report an increase in the college/international population at the larger universities in the state. Language is a barrier as well as cultural practices which might include only being seen by female practitioners. These students are not eligible for medicaid except emergency medicaid, are not citizens, have no social security card, have special financial/resource issues due to lack of finances and insurance.

One district reported they have an Amish population in one of their counties that do not seek traditional medical care. Pregnant women are followed in their homes by a nurse practitioner for prenatal care and delivery. They do not allow newborn screening or immunizations. Another district reported that some minority populations are still having home deliveries.

Because some county health department clinics are not providing prenatal care, the MSDH sometimes has difficulty accessing these patients for enabling services. Some districts are placing public health nurses in delivering hospitals to identify these patients and assist with postpartum and infant needs.

Perinatal High Risk Management teams (nurse, nutritionist, social worker) in some districts, are placed in larger prenatal care providers offices/clinics that see Medicaid/low income clients to offer services.

Infrastructure Building Services

Infants

Districts and county health departments are collaborating with both traditional and non-traditional partners such as schools, head starts, etc. One district reported that services for home visiting mothers and infants after delivery are being provided through cooperative agreements with local hospitals. In this same district, the WIC program is working closely

with Cooperative Extension Home Economists to help provide nutrition education to low risk WIC clients.

The Coastal Plains district stated that they have the privilege of having a very savvy service provider and advocacy network. Although each agency, whether public or private, is currently involved in their own provider challenges, this group of providers from all segments work on a regular basis to network in the effort of coordinating services for users regardless of the type of need requested.

CONSUMER SATISFACTION-see section on Women's Health

Infrastructure Building Services

Child and Adolescent Health

Client and Community satisfaction surveys were completed in all districts, although some are done routinely on an annual basis (eg. WIC marketing survey). Needs included increased staffing as well as facility upgrades, in some cases, and decreased waiting times in all cases; and the incorporation of a Child Health Data System. Training needs included Postpartum home visitation certification, environmental nursing assessments, DenverII developmental train the trainer sessions, Mississippi Association for Public Health Physicians (MAPHP) Conferences, Chronic Disease Obesity conference, Nurse Practitioner and other staff training, and District inservices.

Infrastructure Services

Children with Special Health Care Needs

A child health data system is being developed to address the need for an accurate and effective data collection and analysis system. There is a specific need to explore covering asthma and diabetes in children. In reference to the health indicator relating to asthma, the MSDH Title V staff are exploring ways to develop a measurement for this particular indicator. Some degree of CMP coverage may assist us in developing such a measure.

Special Sub-Populations
The Hispanic population is increasing in Mississippi and outreach efforts are underway to provide maternal and child health services to this population. There may be a need to increase efforts to make interpreter services available in some areas of the state.

Gaps in Services
Six of the nine public health districts listed transportation as a problem which limits access to

care. One district stated that the only public transportation is through LIFT whose priority is the elderly. Jackson has public transportation, but that district also has transportation problems in the rural areas. The coastal area sited the need for expanded transportation routes at reduced rates. For the Medicaid population, there is through Medicaid non-emergency transportation, but there has been some problems accessing this resource. Several districts listed accessing mental health services as a problem. One district stated that it takes approximately two months to get an appointment for services. Two districts stated that detox, treatment, residential facilities and transitional housing for substance abusing women is lacking in their districts. In one district, there is only one domestic violence shelter and no rape crisis centers.

In one district, three out of their nine counties have no delivering hospitals. Two out of their nine counties have no physicians that see maternity patients. In another district, five of the ten counties have no OB/GYN coverage or delivery facility. The average driving time for these women to the nearest facility is about one hour. In one district, OB/GYN and delivery hospitals are not available in every county. Delivery services are available in four counties and OB/GYN services in three. Even though Medicaid transportation funds are available, these long distances that patients have to travel to access services are inconvient. Long distance travel for some clients is required to the only tertiary center in the state.

Other gaps in services include no after hour or weekend prenatal clinics; no local childbirth or parenting classes in rural areas; slow processing of clients for Medicaid eligibility which hampers them accessing care in the private sector; limited low income housing available; employers not wanting to allow women time to come to prenatal appointments; lack of financial resources or medical insurance for the working poor and sub-populations; and the lack of services for uninsured women in the age range forty-five and above.

According to information gathered from the Children's Medical Program Provider Survey, there is a need for a system for patient tracking and data collection, coverage for cochlear implants, improved integration with the University Medical Center, and improved communication with primary care providers regarding comprehensive plans of care for children with special health care needs.

3.2 Health Status Indicators

3.2.1 Priority Needs

The current five year needs assessment reflects numerous needs for women, infants, children, adolescents, and children with special health care needs. The following is a summary of the key conclusions of this needs assessment organized by the levels of the pyramid.

Direct Health Care

Maternal mortality is still a concern in the state. Mississippi also has major problems in the areas of births to teenagers and unmarried women, quantitatively inadequate prenatal weight gain, and maternal substance abuse.

The MCH programs are often the first point of entry into the health care system for many women and children, thus, it is essential that other community resources, private and public, be coordinated with health department services. In developing the health service system, a comprehensive, community based, culturally sensitive approach has been used to encompass both the public and private health resources, as well as linkages with social and rehabilitative services. Hospitals play a back-up role. Community health centers and rural health clinics are filling some of the gaps in the health delivery system, but they are not integrated into a single system of care for poor mothers and children. Demonstration projects in various parts of the state benefit some populations, but do not contribute to the development of the overall system, except to serve as models for what might be. Most of the providers of care to the poor, including the MSDH, are dependent on Medicaid. As Medicaid continues to move into a managed care mode many of these providers may need to become part of the managed care system or to change their roles. The MSDH must devote sufficient attention to the coordination of the maternal and child health care providers outside its own system.

Enabling Services

The infant mortality, neonatal and postneonatal rates far exceed the Year 2000 objectives for IMR of 7.0 for all races, 11.0 for blacks. Among whites, the rising postneonatal rate is increasing the overall IMR for this group. The causes of infant mortality are usually ranked in the following order: 1) congenital malformations, 2) short gestational period and low birth weight, and 3) SIDS. In 1998, SIDS is ranked number 3, indicating a possible source of rising postneonatal deaths and infant mortality. Mississippi should address these problems with promotion and education programs aimed at the appropriate target population.

Adolescent health indicators are poor and indicate a need for coordinated efforts in education to reduce rising risky behavior. Teen pregnancies are extremely high, while tobacco use and other substance abuse clearly are contributing to the poor outcomes. STD rates and a belief that condoms do not help prevent STDs are helping to increase perinatal risks. Intervals between pregnancies are short, and this is likely to add to the increasing infant mortality rate.

HealthMACS, the Mississippi Medicaid managed care system introduced in 1993 is now in place statewide. The Title V Agency has a role in helping the MCH population fully access the new HealthMACS system within the state.

In addition to the funds available to the CMP from the CSHCN section of Mississippi's Title V allocation, children with special health care needs and their families obtain assistance from Medicaid, the Supplemental Security Income Program for Disabled Children (SSI), and private sources.

Population Based Services

Mississippi has done an outstanding job in immunization efforts, creatively using Head Start, WIC, community health centers (CHCs), and nontraditional sites, such as National Guard armories, to help in the efforts. MSDH has an active lead screening program, although screening efforts in the private sector are believed to be less than the health department's. Thus, Mississippi will need to extend education and outreach to the health care provider community.

The lack of adequate monitoring and follow-up of blood lead levels, poor nutritional levels and weight gains, and large numbers of childhood injuries, as well as the low level of EPSDT screenings, prohibit a more comprehensive preventive approach to child health. Increased monitoring may be possible as better data systems become available throughout the system.

At present, there are only two tertiary centers in the state, the UMC in Jackson, and the Keesler Air Force Base Hospital on the Gulf Coast. There are 13 hospitals designated as Level II facilities with neonatologists and another 26 as Level II without a neonatologist. Considering these limitations, the Title V Agency should work to assure access to appropriate medical care for all MCH populations, including women, infants, children, and children with special health care needs.

Infrastructure Building Services

As of June 16, 1999, 63 areas in the state were designated as Health Professional Shortage Areas (HPSAs) and were eligible for National Health Service Corps practitioners to help provide service. At that time, the MSDH Primary Care Development Program estimated that it would require 111 professionals to remove the HPSA designations.

Efforts at developing a data system that allows on-going and current data to be accessed for purposes of assessing need and program planning are rather recent in Mississippi. Getting all the necessary public and private entities linked into the system will continue to be a primary goal of the MSDH. Data collection and data

sharing by all the county health departments, district health offices and the state health department will assist the state in understanding shifts and changes in populations and programs.

A family-focused, comprehensive, and coordinated system of care for all of Mississippi's children is not yet realized. In the absence of reliable incidence and prevalence data for children with disabilities, health status indicators and national estimates have been used and they indicate a large unmet need. Efforts to identify CSHCN have been hampered in the CMP because of limited personnel and insufficient surveillance systems. Educational efforts at the community level regarding the Children's Medical Program and its eligibility criteria are coordinated through the county health department staff. Priority must be placed on assuring that appropriate service coordination is available for every child and family in the program. Making such a system of care a priority and a reality will require integrated planning and exploration of how to best utilize the various funding streams available for this population.

Although several problems have been identified that adversely affect the provision of services to Mississippi's women and infants, children and adolescents, and children with special health care needs, the following priorities have been selected as a means of improving the status of maternal and child health services in our state as a result of the MCH needs assessment:

1. Reduce repeat teen births.

2. Improve data collection capacity for Title V population.

3. Explore coverage of asthma services for children.

4. Increase EPSDT screening among children on Medicaid.

5. Reduce the state's low birthweight rate and infant mortality rate.

6. Develop a plan to identify, gather data on, and address issues related to maternal deaths.

7. Decrease cigarette smoking among ninth through twelfth graders.

8. Decrease the incidence of teen mortality and unhealthy behaviors.

9. Assure access to pediatric care for all children, including children with special health care needs.

10. Decrease cigarette smoking among pregnant adolescents.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

(See Forms 2, 3, 4, and 5 For Application Fiscal Year in 5.3 Other Supporting Documents)

Budget Justification (Narrative)

The budget for Mississippi's MCH Block Grant application was developed by the Office of Personal Health Services in cooperation with the Office of Administrative and Technical Support, Bureau of Finance and Accounts. The total program for FY 2000 is **$19,172,482** of which **$10,928,315 (57percent)** is Title V and **$8,244,167 (43 percent)** is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

The MSDH will expend funds for the four types of services (Core Public Health/Infrastructure, Population Based Individual Services, Enabling and Non-Health Support, and Direct Health Care Services). Services will target the three categories including pregnant women and infants, children and adolescents, and Children with Special Health Care Needs, specifically those in families living at or below 185percent of the federal poverty level. This includes services to be provided or coordinated for individuals, by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like). The three components and the anticipated expenditure amounts are described below:

Component A, Services for Pregnant Women and Infants, is budgeted as follows for FY 2001: **$3,278,495** for federal funds (**30 percent** of the total federal award), **$2,803,016** for non-federal funds (**34 percent** of total non-federal funds).

Component B, Services for Child and Adolescent Health, is budgeted as follows for FY 2001: **$3,278,495** for federal funds (**30 percent** of the total federal award), **$2,720,575** for non-federal funds (**33 percent** of total non-federal funds).

Component C, Services for Children with Special Health Care Needs, is budgeted as follows for FY 2001: **$3,278,495** for federal funds (**30 percent** of the total federal award), **$2,720,575** for total non-federal funds (**33 percent** of total non-federal funds).

Administrative Costs are budgeted at $**1,092,831** which is **10** percent of the total federal grant award. This amount will not exceed the allowable **10 percent** of the total MCH

Block Grant as mandated in OBRA 1989. The rate for FY 2001 is **16.0 percent** of salaries and fringe benefits (approval pending).

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Typically, classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $.32.5 per mile. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Equipment including minor medical and office, may be purchased in order to administer the program. The equipment items are minor parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction none.

Other includes telephone, copying and postage used on behalf of the block grant program.

3.3.2 Other Requirements

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 1998 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989 as indicated below:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
FUNDS AVAILABLE TO MATCH THE MCH BLOCK GRANT

FISCAL YEAR 1989

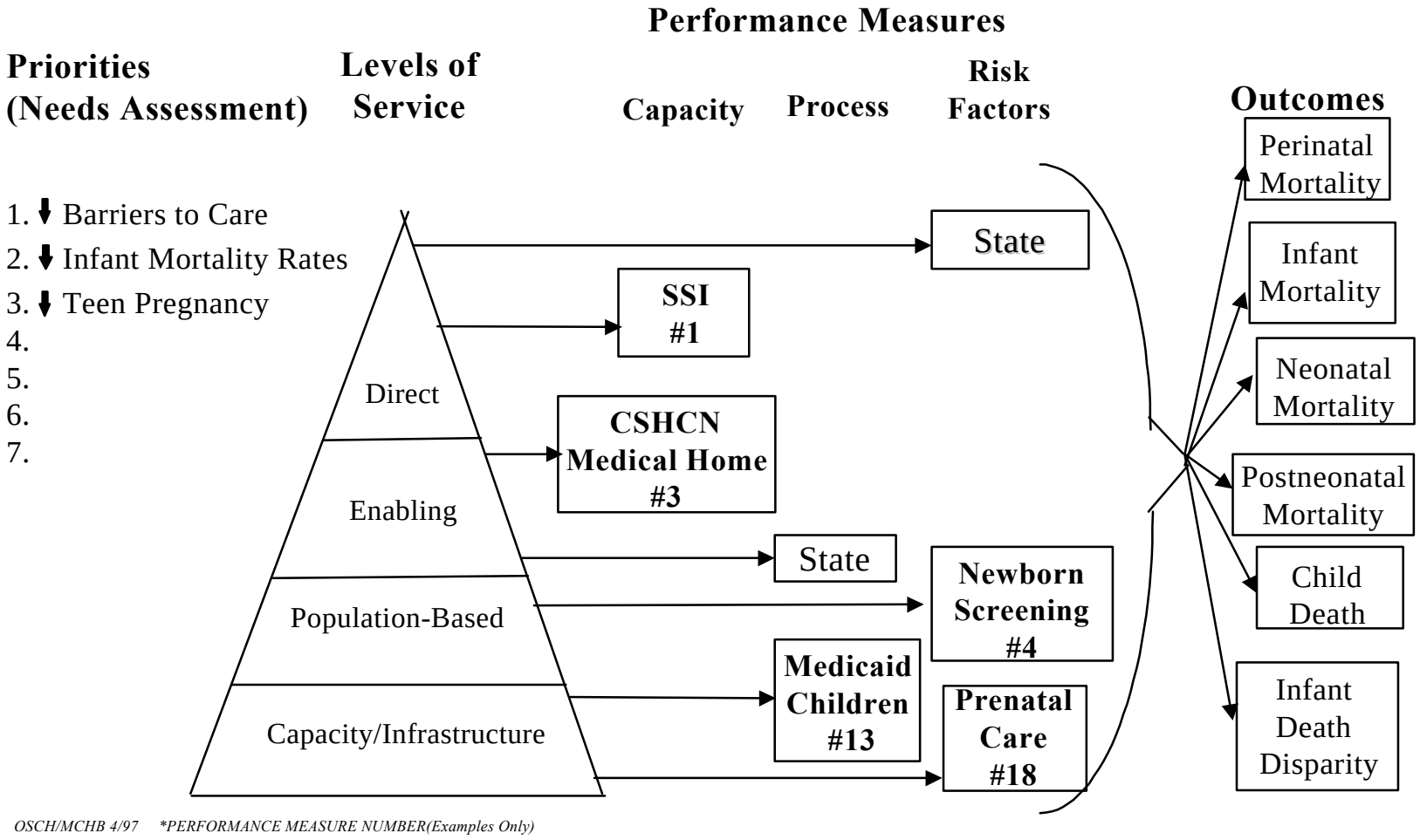
	TOTAL	MCH TIME PAID BY ST/LOCAL FUNDS	DIRECT PROGRAM EXPENDITURES			
			STATE & LOCAL	MEDICAID/ INSURANCE	OTHER	NON-FEDERAL
Perinatal Services	2,196,980	489,865	898,366	385,349		423,400
Child/Adolescent	2,096,528	1,884,776	112,072	99,680	0	
CSHCN	2,283,147	281,994	1,892,571	108,582		0
Indirect Cost	0					
Total Amt. Spent	6,576,655	2,656,635	2,903,009	593,611		423,400

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted. All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts are used to match the Perinatal Services category. Time coded to Child Health, Dental Health and School Nurse is used to match the Children and Adolescent category.

3.4 Performance Measures

Figure 3

Title V Block Grant
Performance Measurement System



*OSCH/MCHB 4/97 *PERFORMANCE MEASURE NUMBER(Examples Only)*

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Targets
(See Form 11)

3.4.2 State "Negotiated" Five Year Performance Measures
(See "negotiated"measures below)

3.4.2.1 Development of State Performance Measures
(See Form 16)

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of children on Medicaid who receive EPSDT Screening.	X					X	
2) Current percent of cigarette smoking among ninth through twelfth graders.			X				X
3) Smoking among pregnant adolescents.			X				X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
4) Percent of children with genetic disorders who receive case management services.			X				X
5) Infants screened and referred for hearing impairment $35 dB nHL will receive appropriate follow-up and intervention upon hospital discharge.	X						X
6) Prevalence of infants born with neural tube defects.				X	X		
7).The rate of repeat births (per 1,000) for adolescents less than 18 years old.			X				X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

On September 9-10, 1999, the MSDH Office of Personal Health Services hosted a conference entitled "Planning and Partnerships for Mississippi Mothers and Children" at the Eagle Ridge Conference Center in Raymond, Mississippi. The purpose of the conference was to build statewide knowledge and skills in assessing needs, planning, and building partnerships to enhance the health of mothers, infants, and children in Mississippi. This conference served as a kickoff for the district level data collection for the statewide Maternal and Child Health Needs Assessment. Members of the MCH Block Grant Workgroup were designated as leaders for the Statewide Title V Needs Assessment process. Representatives of the MCH Block Grant Workgroup were charged with going back to their respective districts and collaborating with pivotal local community leaders and service providers germane to the collection of data on services available to their Title V population. Workgroup members were given a deadline for completing the data collection process and reporting this information to central office staff. Immediately following the synthesis and analysis of all data collected for the Statewide Needs Assessment, a second conference was scheduled to present the findings of the data collection process to Workgroup members and designated key community leaders and service providers from each public health district. Then Workgroup members participated in identifying high risk populations, prioritizing state problems, and developing activities to meet the State Performance Measures.

List of Priorities:

1. Reduce repeat teen births.

2. Improve data collection capacity for Title V population.

3. Explore coverage of asthma services for children.

4. Increase EPSDT screening among children on Medicaid.

5. Reduce the state's low birthweight rate and infant mortality rate.

6. Develop a plan to identify, gather data on, and address issues related to maternal deaths.

7. Decrease cigarette smoking among ninth through twelfth graders.

8. Decrease the incidence of teen mortality and unhealthy behaviors.

9. Assure access to pediatric care for all children, including children with special health care needs.

10. Decrease cigarette smoking among pregnant adolescents.

3.4.2.3 Five Year Performance Objectives

(See Form 11)

3.4.2.4 Review of State Performance Measures

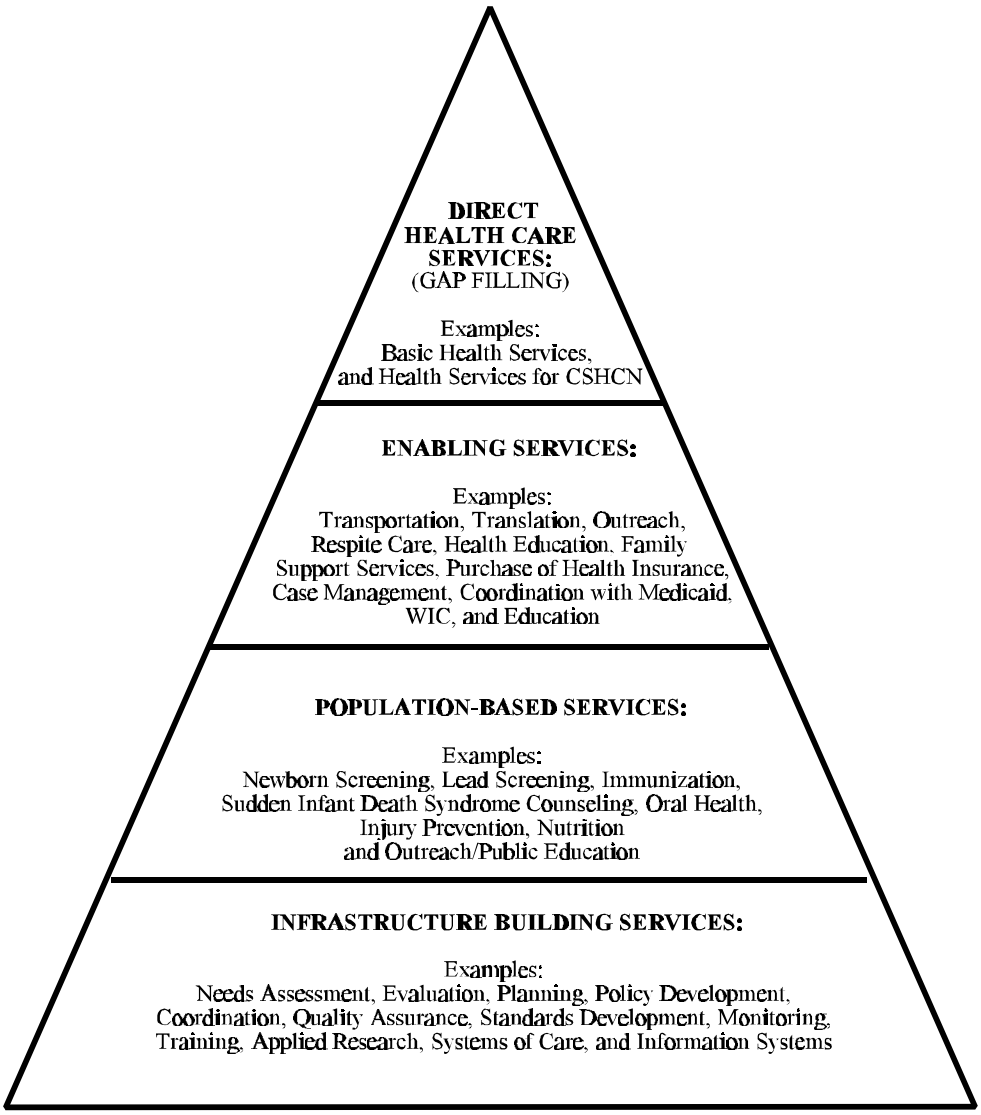
3.4.3 Outcome Measures

(See Form 12) No additional outcome measures were developed by Mississippi.

III. REQUIREMENTS FOR APPLICATION

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

IV. REQUIREMENTS FOR THE ANNUAL PLAN

State Title V Resources

The Mississippi State Department of Health's (MSDH) Office of Personal Health Services (OPHS), through the Bureau of Women's Health and the Bureau of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: pregnant women and infants, children and adolescents, and children with special health care needs (CSHCN). Support clinical services are provided to the target populations through local county health departments and speciality clinics.

The MSDH operates a statewide network of local health departments and specialty clinics which serve the Maternal and Child Health (MCH) population. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

County level efforts are coordinated through nine public health districts which function under the specific direction of a District Health Officer (a physician), who directly supervises a District Administrator and District Chief Nurse. The District Chief Nurse oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator. These coordinators are also nurses who specifically provide direction and quality assurance for MCH and family planning programs throughout each district. With programs that serve children and families located in the same office, the MSDH is able to avoid duplication of services among the various programs and maximize available human and fiscal resources.

The MSDH Child Health Program provides well and sick child services to children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Child health services are available statewide to children living at or below 185 percent of the poverty level and to other children with poor access to health care. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services are basically preventive in nature and designed for early identification of crippling conditions.

Children With Special Health Care Needs

Children in need of further care are linked with other MSDH programs and/or private care providers necessary for effective treatment and management. This assures cost-effective services which are acceptable to patients, promote good health, prevent occurrence of progression of illness and disability, and restore the functionally damaged child so far as is practical. Adjunct services such as the Genetic Screening Program, the Early Intervention Program, and the Children's Medical Program are important components of the Bureau of Child Health.

Children's Medical Program

The Children's Medical Program provides medical and/or surgical care to children with chronic or disabling conditions. Program services are available to state residents through 20 years of age. Conditions covered by the Children's Medical Program include major orthopaedic, neurological, and cardiac diagnoses, and chronic conditions such as cystic fibrosis, sickle cell anemia, and hemophilia. The program provides community-based specialty care through 19 clinics throughout the State, including a multi-disciplinary clinic centrally located in Jackson at Blake Clinic for Children. In FY 1999, the program spent over six million dollars on diagnostic and treatment services for Mississippi CSHCN. Services included hospitalization, physician services, braces and other appliances, prosthetic devices, medications, respite services, case management, social work, physical therapy, and speech therapy. Each of the nine Public Health Districts in the State has a CMP/Genetics coordinator (either a nurse or a social worker) who assists with care coordination to meet the needs for CSHCN and their families in their local areas.

The CMP has a very strong link with the county health department system which is based in 81 counties of the state. This system is utilized to provide community based CMP application sites, screening and referral services, as well as a base of operations for central office staff when clinics are conducted at the community based level. The CMP has developed very effective lines of communication with the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parents groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to make sure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes the CMP Advisory Council to communicate with and receive feedback from health care providers and consumers. The Advisory Council includes specialty and sub-specialty physicians, (pediatricians, pediatric orthopaedic surgeons, pediatric cardiologists, etc), dentists, physical therapists and other health care providers, and parents of CMP patients. Through this effort, providers are advised of program efforts such as the expanded effort to provide services to disabled children under sixteen years of age who receive SSI benefits under Title XVI, and the

coordinated efforts to assist CMP patients in finding medical home.

The Needs Assessment Plan developed in the State System Development Initiative was accomplished. Plans for the second year will require the institutionalization of data reporting.

Genetics

The Genetics Program has developed comprehensive genetics services statewide including screening, diagnosis, counseling, and follow-up of a broad range of genetic related disorders. Seven genetics satellite clinics and five sickle cell satellite clinics are strategically located in the state, making genetics services more accessible.

Genetic Services now include the following:

1. hemoglobinopathy services (screening, education, follow-up and treatment)
2. clinical genetics (genetics clinics, education and treatment)
3. newborn screening/birth defects registry (newborn screening, birth defects database registry and tracking)
4. case management and provider education (education to over 70 hospital nurseries/laboratories and 120 health departments clinics).

Sickle Cell Disease Program

Sickle cell anemia can be prevented only in future generations through genetic counseling. Children and adolescents diagnosed as having sickle cell disease or carrying the sickle cell trait can receive genetic counseling through the MSDH Genetics Program to make wise decisions about contraception. The MSDH Sickle Cell Program aims to improve services to children and adolescents with sickle cell disease by screening and counseling in the communities.

Several other health service agencies conduct sickle cell disease research and education. Sickle Cell Anemia Research and Education Inc., performs research and provides free confidential testing, private counseling, total patient care, and public and private educational programs. The March of Dimes supports research to identify drugs which will safely inhibit the sickling process in red blood cells in sickle cell disease patients.

Early Intervention

First Steps Early Intervention Program (FSEIP) is Mississippi's early intervention system for infants and toddlers with special developmental needs and their families. First Steps is implemented through an interagency system of comprehensive developmental services for eligible infants and toddlers. The statewide system seeks to minimize the impact of a disabling condition on an infant or toddler and his or her

family by identifying and utilizing to the maximum extent possible community based resources. The process of identification of an eligible infant to the provision of services and transition of the toddler into an appropriate educational setting is well orchestrated in keeping with the regulations of the Individuals with Disabilities Education Act (IDEA) Part C.

Mississippi serves all eligible infants and toddlers and their families. It provides child find, provision of procedural safeguards, service coordination, evaluation and assessment, and transition services free of charge to families. After a comprehensive, multi-disciplinary evaluation and assessment, specialized developmental services may be provided to the child and family in accordance with an individualized family service plan (IFSP). All services are currently provided at no cost to families. Cost for specialized developmental services may be charged to private insurance or Medicaid. If the family has no form of insurance coverage, the MSDH as the lead agency may pay for services as "payor of last resort."

Children/Adolescent Health Services

School Mouth Rinse Program

The School Fluoride Mouth Rinse Program is a preventive program in which elementary school children rinse weekly with 0.2percent sodium fluoride solution. The goal is to continue to maintain a participation level of 50,000 children. Fluoride mouth rinse activities are population based prevention services and utilize school staff in the participating school systems around the state.

Community Water Fluoridation- Fluoridation of community water systems continues to be the most effective public health measure in decay prevention. The effectiveness of prevention remains at 45-50percent. Mississippi maintains a community fluoridation level of 50 percent. Efforts to expand services are continued by making water systems aware of the availability of fluoridation assistance from the MSDH to water operators on a first-come, first-serve basis.

Dental Corrections Program-The Dental Corrections Program purchases dental care for indigent children with severe dental problems who do not qualify for any third party coverage (insurance or Medicaid). Most of these children are under 5 years and require full mouth dental rehabilitation as a result of prolonged bottle feeding. Services provided through this program are direct personal health care by category of primary dental care and hospitalization through purchase of service.

Statewide Dental Screen of Third Grade Students

In an effort to address Core Performance Measure #07 regarding the percent of third grade children who have received protective sealants on at least one permanent molar tooth, the Mississippi State Department of Health (MSDH) has entered into a contract with Dr. Stephen L. Silberman and the University of Mississippi School of

Dentistry to screen third public school grade students in each of Mississippi's nine public health districts. A stratified sample of schools will be selected using the criteria below. Data will be collected utilizing an Oral Health Screening Form for School Children developed by the Association of State and Territorial Dental Directors. Background information collected on each student will include the screening date, school code, screener's unique identification number (ID), student's unique ID, birthrate, age, gender, and race. To ensure that this study has highest probability of providing accurate answers to the questions, the following criteria will be employed:

- all nine public health districts will be included in the sample,
- schools will be the sampling unit,
- schools to be chosen will be representative for the size of the school as well as the community it represents,
- the sample will be drawn randomly from each public health district and randomly within each district to account for school size,
- Investigators will be standardized regarding procedure to be followed and data to be collected and calibrated to account for interrater and intrarater reliability.

A stratified random sample has been drawn to include approximately 5400 students in 75 schools throughout the nine public health districts in Mississippi. The proposed sample will provide accurate answers to the questions posed with an error margin of ±5percent. Data collected during this project will serve as baseline data for future comparisons.

Immunization Program

Based on a Memorandum of Understanding between the Mississippi Department of Education and the Mississippi State Department of Health to meet **Healthy People 2010** objectives for providing a quality comprehensive school health program and on recommendations by the Advisory Committee on Immunization Practices, a program has been implemented to provide recommended adolescent immunizations in school districts in the State. The purpose of this project is to improve the delivery of vaccination and other preventive services to adolescents in Mississippi. The school-based immunization program makes available immunizations for sixth grade students not previously vaccinated with a booster dose of tetanus and diphtheria vaccine, a second dose of measles, mumps, rubella vaccine, the hepatitis B vaccine series and, if indicated, the varicella vaccine.

Benefits from this type of immunization program in school districts include: (1) adolescents who routinely do not receive medical care will be provided needed vaccines; (2) vaccinated students will have a long-term protection from potentially debilitating diseases; (3) the family will be saved both time and medical expenses as students who participate will be given the vaccines at the school site and at no charge;

and (4) individuals participating in this program will learn the importance of immunizations for themselves and their families and hopefully, develop an understanding of the need for immunizations throughout their lifetime.

Abstinence Education Program

Mississippi's Abstinence Education Program is designed to implement strategies to work at reducing unintended pregnancies and/or out-of-wedlock births by implementing a statewide abstinence education program to prevent untimely pregnancies in youths 10-19 years old. The objectives of the program are to: (1) gain community/consumer involvement and support for abstinence education by securing abstinence education contracts with local school districts and community-based organizations (CBOs) such as churches, independent contractors, nonprofit, or other qualifying organizations to implement abstinence education as described in P.L. 104-193, Section 510; (2) dissuade youth age 10-19 from engaging in sex before adulthood or marriage and; (3) reduce the number of out-of-wedlock births to teens.

Family Planning Services

In addition to assuring that adolescents have access to family planning services such as medical and non-medical counseling about abstinence methods of contraception, medical examination, provision of contraceptives, pregnancy testing, and counseling, the MSDH's Family Planning Program also provides up-to-date abstinence and reproductive health educational materials to school districts aimed at reducing risky behavior among adolescents. Presentations in school systems are provided to students by health educators, MCH/FP Coordinators, FP Nurses, and County Coordinating Nurses.

School Nurse Program

School nurses in Mississippi work to promote and protect the health status of adolescents and staff through health services and health education. As of October 1999, there are 290 nurses in Mississippi public schools. Fifty-six (56) of the 290 nurses are supported by tobacco settlement dollars to reduce and/or prevent the use of tobacco products among youth and other risky behaviors.

School nurses have a number of responsibilities which includes: screening students for hearing and vision problems; visiting students at home who are classified as homebound; providing staff development for communicable and contagious diseases; checking students for head lice, dental problems, and scoliosis; identifying asthma; communicating with physicians or mental health care providers; providing and monitoring routine medications for students; training students and staff on diabetes and providing sugar checks; and maintaining and implementing strategic plans for treating emergencies.

Health Promotion and Education

The Division of Health Promotion and Education provides and supports services aimed at school, community health, and worksite programs to improve the health of Mississippians. Health educators work with community groups, schools, and clinics to implement health promotion programs.

The Health Promotion Clearinghouse provides resources and research about science-based programs to improve health. The Division conducts the Youth Risk Behavior Survey and disseminates results to decision-makers and agencies serving youth. Risk factor data from the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System guide operational objectives for local interventions.

Women's Health Services

The MSDH Women's Health programs provide women with or ensure access to comprehensive health services that affect positive outcomes, including early cancer detection, domestic violence prevention and intervention, family planning, and maternity services.

Breast and Cervical Cancer

The Breast and Cervical Cancer Early Detection Program works to reduce high morbidity and mortality caused by breast and cervical cancer in Mississippi. The program has seven objectives: (1) to establish a system for screening women for breast and cervical cancer as a preventive health measure; (2) to provide appropriate referrals for medical treatment of women screened in the program and to ensure, to the extent practical, the provision of appropriate diagnostic and treatment services; (3) to develop education and outreach programs and to disseminate public information for the early detection and control of breast and cervical cancer; (4) to improve the education and skills of health professionals in the detection and control of breast and cervical cancer; (5) to establish mechanisms through which Mississippi can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; (6) to establish mechanisms to enhance the state's cancer surveillance system to facilitate program planning and evaluation; and (7) to ensure the coordination of services and program activities with other related programs.

The target population for the program is uninsured, underinsured, and minority women. Women 50 to 64 years of age are the target group for mammography screening, and women 18 to 64 years are the target for cervical cancer screening.

Domestic Violence/Rape Prevention and Crisis Intervention

The Domestic Violence/Rape Prevention and Crisis Intervention Program provides specific resources through contracts with domestic violence shelters and rape crisis programs. In addition, the program makes brochures, educational materials, and a

display available.

The domestic violence shelters provide direct services to victims of domestic violence, including children, and education regarding domestic violence and the impact that can be made on the cycle of violence. The rape crisis programs provide direct services to victims of rape and sexual assault and provide a public awareness campaign aimed at reducing the incidence of sexual assault.

Family Planning

The Family Planning Program promotes awareness of and ensures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. Approximately 96,751 Mississippians received comprehensive family planning services in CY 1999, and some 30,867 of those were age 20 years or younger.

The target populations are teenagers and men and women at or below 150percent of poverty level. A fee system with a sliding scale is used. Under this scale, clients with an income at or below 100percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program provides:

- Medical and non-medical counseling about methods of contraception
- Medical examination and provision of contraceptives, and
- Pregnancy testing and counseling

The family planning program also provides blood pressure screening, breast/cervical cancer screening, follow-up of abnormal Pap smears and treatment, treatment for sexually transmitted diseases, preconceptual care, sterilization, and infertility services. Access to other MSDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families, as needed. The MSDH developed a request for an 1115 waiver for Medicaid that would expand family planning services for postpartum women at or below 185percent of the federal poverty level to two years. The request was passed by the 2000 Legislature which gives permission to Medicaid to submit to their federal fiscal agency, Health Care Financing Administration (HCFA).

Maternity

MSDH Maternity Services aims to reduce low-birthweight and infant and maternal mortality and morbidity in Mississippi by providing comprehensive, risk-appropriate prenatal care through county health departments. Public health staff on the local level work with private providers statewide to assure planned hospital delivery close to

home tailored to the risk of the mother and infant; they also cooperate to continue care after delivery, particularly including family planning and infant health services.

Approximately 36 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort.

A part-time, board-certified obstetrician provides consultation statewide for the maternity, family planning and Breast and Cervical Cancer Screening programs. The public health team evaluates maternity patients at each visit, using protocols which reflect national standards of care for maternity patients. They place special emphasis on identifying high-risk problems and ensuring appropriate care to reduce or prevent problems. This includes arranging for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Perinatal High Risk Management/Infant Services System

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) provides a multi-disciplinary team approach to high-risk mothers and infants. Targeted case management, combined with the team approach, can better treat the whole patient, improve the patient's access to available resources, provide for early detection of risk factors, allow for coordinated care, and decrease the likelihood of the infant being born too early or too small. These enhanced services include nursing, nutrition, and social work. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Perinatal Regionalization

The regionalization of perinatal services is revered as an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among Very Low Birthweight (VLBW) infants (<1,500 grams). Perinatal regionalization is a system of care that involves obstetric and pediatric providers, hospitals, public health, and includes outreach education, consultation, transport services, and back-transport for graduates from the Neonatal Intensive Care Unit (NICU).

The success of a perinatal regionalization system depends on identification and appropriate referral of women with high-risk pregnancies, maternal transport when indicated, and stabilization and transport of sick infants to hospitals with higher level perinatal services when indicated. Perinatal regionalization agreements that systematically promote the health of the mothers and infants are usually implemented through legislation, administrative rule, guidelines, or voluntary cooperation.

Mississippi uses voluntary cooperation in implementing its perinatal regionalization system of care, although the system is not completely developed. According to a white paper entitled "Regionalized Perinatal Health Care for Mississippians" (Pittman, 1990), Mississippi's regionalization system is described as "fragile" and "embryonic, " with continuing problems with support for the Perinatal Center at the University of Mississippi Medical Center (UMMC), access to care (especially transportation needs), a large proportion of population in poverty, and lack of insurance still exist. In addition, the system is showing signs of change. There has been a drop in the percent of women receiving prenatal care at Mississippi State Department of Health (MSDH) clinics. The percent of expectant mothers receiving prenatal care at MSDH clinics declined from 50percent in 1990 to 42percent in 1996 (MSDH, 1998), and MSDH districts are reporting further decreases in maternity services.

Fetal and Infant Mortality Review

In 1997, Mississippi was a recipient of a three year SPRANS (Special Projects of Regional and National Significance) grant to conduct fetal and infant mortality death reviews in six counties in Public Health District I. Fetal and Infant Mortality Review (FIMR) is a community owned, action-oriented process that results in improved service systems and resources for women, infants and families. The FIMR process brings a community team together to examine confidential, de-identified cases of infant deaths. The purpose of these reviews is to understand how a wide array of local, social, economic, public health, educational, environmental and safety issues related to the tragedy of the loss.

Supplemental Nutrition Program

WIC, the special supplemental nutrition program for women, infants, and children improves the outcome of pregnancies; reduces health problems associated with poor nutrition during pregnancy, infancy, and early childhood; and reduces infant mortality.

The WIC Bureau provides special supplemental food and nutrition education to low-income pregnant, postpartum, and breast-feeding women, infants, and preschool children who have nutrition-related risk conditions. The foods WIC provides are especially high in the nutrients protein, iron, calcium, and vitamins A and C. Operating in all 82 counties, WIC served an average of 107,113 participants per month during the first six months of FY 1999.

WIC is an incentive for early entrance into the expanded maternal and child health delivery system and is an important component of a comprehensive preventive health service. Infants and children are eligible if they show signs of poor growth, anemia, obesity, chronic illness, or nutrition-related diseases. Pregnant and postpartum women are considered at risk if they are younger than 18 or older than 35, have a poor obstetrical history, are

anemic, or gain weight at an undesirable rate.

4.1 Program Activities Related to Performance Measures

Direct Health Care

Pregnant Women, Mothers and Infants

(Priority #5)
SPM #6: Prevalence of infants born with neural tube defects.

1. Implement initiatives to ensure that women in the reproductive age range consume the appropriate amount of folic acid for improved pregnancy outcome.

   Activities:

   1. Counsel women in family planning clinics regarding the need for the daily consumption of folic acid or a multi-vitamin containing 0.4 mg of folic acid for all women capable of becoming pregnant.
   2. Partner with the March of Dimes, UMC Department of OB/Gyn to provide multi-vitamins to family planning clients in two public health districts and track their compliance.
   3. Make folic acid available to the MSDH Family Planning population either by providing a folic acid supplement or by providing the client with a prescription.
   4. Print folic acid message on MSDH bags used to distribute MSDH pharmacy prescriptions to heighten awareness of the importance of taking folic acid.
   5. Provide folic acid education to all women requesting premarital blood tests.

   Monitoring:

   1. Review Family Planning records for folic acid counseling and/or issuance of a prescription.

   Evaluation:

   1. Increase or decrease in prevalence of infants born with neural tube defects.

Preventive/Primary Care Services for Children/Adolescents

(Priority #4)

SPM #1 Percent of children on Medicaid who Receive EPSDT Screening.

1. Increase access to health care for children on Medicaid.

   Activities:

   1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings.
   2. Provide information about EPSDT in WIC Packets.
   3. Remind parents at immunization visits to seek health care and the importance of EPSDT.
   4. Check whether EPSDT sreenings are due on children being seen for WIC services and screen if granted permission by the Primary Care Provider (PCP).
   5. Work with Medicaid to waive requirement to have PCP authorize this service.

   Monitoring:

   1. Review EPSDT audit findings.
   2. Review Medicaid reports to MSDH

   Evaluation:

   1. Medicaid EPSDT screenings will significantly increase.

Services for CSHCN

(Priorities #9)

NPM #1: The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

1. Identify the percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children With Special Health Care Needs (CSHCN) Program.

   Activities:

   3. Collaborate with other state and national agencies to determine the number of SSI beneficiaries under age 16.
   2. Maintain a working relationship with the State's Disability Determination Services Office to assess potential eligibility and

cross referral of clients.

3. Verify the status of SSI enrollees who apply for CMP services.

Monitoring:

1. Maintain current Memorandum of Understanding with Disability Determination Services.

Evaluation:

1. The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.
4. The proportion of Medicaid eligible children less than 16 years of age receiving rehabilitative services for the State CSHCN Program.

(Priority #9)

NPM #2: The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients.

1. Identify all potential sources of health coverage for CSHCN and develop a hierarchy of payment by category of services to assure referrals are to appropriate primary sources of coverage.

Activities:

2. Continue to coordinate with the Early Intervention Program to locate and appropriately refer children with special health care needs under 3 years of age to possible financial resources to provide necessary care.
3. Identify resources.
4. Develop referral agreements.
5. Develop care plans.
6. Assess care plans/changing needs quarterly.

Monitoring:

1. Conduct case reviews of a sampling of all cases served to determine when appropriate referrals have been made.

Evaluation:

1. Review of sample of cases covered by CSHCN program to determine if CSHCN program was payor of last resort.

2. Coordinate medical coverage of eligible CSHCN patients with providers to ensure comprehensive, effective care.

   Activities:

   1. Identify patients during the application process who do not have Medicaid coverage but may be eligible.
   2. Review all annual application updates.
   3. Request providers to accept other third-party pay sources to whatever extent possible.
   4. Continue to coordinate with the University Medical Center to provide care coordination for Pediatric Cardiology, Pediatric Orthopedic, and Cystic Fibrosis, and Hemophilia patients.
   5. Develop CMP case management positions (as funds allow) to provide care coordination services in other subspecialty areas.
   6. Maintain current Memorandum of Understanding with the State's Disability Determination Services (DDS) to document cross-referral and the resource sharing between agencies.
   7. Utilize MSDH's statewide social work staff to assist with assessment and referral, and resource information as needed.

   Monitoring:

   1. Annual review of patient applications.
   2. Monthly review of care plans through case conferences/staffing

   Evaluation:

   1. The degree of specialty, subspecialty, and care coordination services provided or paid for by the State's CSHCN Program.

<u>Enabling Services</u>

Pregnant Women, Mothers and Infants

(Priorities #2 & #9)

SPM #5: Infants screened and referred for hearing impairment $35 dB nHL will receive appropriate follow-up and intervention upon hospital discharge.

Identify infants screened for hearing impairment $35 dB nHL who receive appropriate follow-up and intervention upon discharge.

Activities:

1. Develop protocol for follow-up to include PHRM/ISS, Early Intervention and county child health case management.
2. Refer all infants failing criteria when screened at 35 dB nHL to an audiologist.
3. Monitor speech and language development.
4. Through service coordinators, connect caregivers with available resources.
5. Refer to Part C

Monitoring:

1. In six month intervals, review developmental profiles after diagnosis for infants up to three years of age.

Evaluation:

1. The number of infants screened for hearing impairment $35 dB nHL who receive appropriate follow-up and intervention.

Preventive/Primary Care Services for Children/Adolescents

Services For CSHCN

(Priorities #2 & #9)

NPM #3: The percent of Children with Special Health Care Needs in the State who have a "medical/health home."

1. Review all existing agreements for services with community-based providers.

Activities:

1. Include medical home information on CMP applications.
2. Screen medical home status at all clinic encounters and make referrals as needed.
3. Collaborate with primary care physician groups to increase the availability of medical homes for CSHCN.
4. Continue to coordinate with the University Medical Center to provide care coordination for Pediatric Cardiology, Pediatric Orthopedic, and Cystic Fibrosis and Hemophilia patients.
5. Develop CMP case management positions (as funds allow) to provide care coordination services in other subspecialty areas.
6. Utilize district CMP/Genetics Coordinators to assist in care

coordination at the community level.

Monitoring:

1. Monthly ongoing reviews of medical records to determine medical home status of each CSHCN enrollee.

Evaluation:

1. The percent of CSHCN in the state who have a medical/health home.

(Priorities #2, #5 & #9)

SPM #4: Percent of children With Genetic Disorders who Receive Case Management Services.

1. Insure that children testing positive for genetic disorders receive appropriate case management services.

Activities:

2. Review manually all automated genetic test results of children tested.

2. Report all positive test results to genetic field staff for clinic appointments and follow-up.

3. Home visit positive cases for case management.

4. Home visit and counseling for all positive cases who have not received follow-up.

Monitoring:

1. Continue monthly review of all positive cases to determine current status

Evaluation:

1. Continue to evaluate number of positive cases that remain in system of care for at least 12 months.

<u>Population Based Services</u>

Pregnant Women, Mothers and Infants

(Priority #5)

NPM #9: Percent of mothers who breastfeed their infants at hospital discharge.

1. Implement initiatives to improve the incidence and duration of breastfeeding among women in Mississippi.

   Activities:

   1. Certify and promote MSDH clinics as breastfeeding-friendly facilities.
   2. Continue the nationally recognized peer counselor breastfeeding program through the MSDH's WIC program.
   3. Continue the implementation of USDA's National Breastfeeding Promotion Campaign.
   4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers.
   5. Provide technical training opportunities for health care providers on breastfeeding promotion, technique and management.
   6. Conduct outreach activities with worksites employing large numbers of women in the childbearing age.
   7. Increase collaboration among MSDH agency programs and private providers.

   Monitoring:

   1. Review quarterly the participation reports on WIC breastfeeding women.
   2. Review annually the Ross Mothers National and State Survey of Breastfeeding Initiation and Duration Rates.

   Evaluation:

   1. Increase in the number of women participating in the WIC program that are breastfeeding.
   2. Number of all women currently reported breastfeeding, including WIC participants, compared to previous breastfeeding rates.
   3. Increase in the number of women who breastfeed at hospital discharge and continue breastfeeding for at least six months.

(Priority #9)

NPM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

The implementation of universal screening at all hospitals for early detection of hearing impairments in newborns.

Activities:

1. Receive and review, through the use of FSEIP Child Find Coordinators, all written, electronic faxed reports from birthing hospitals and/or facilities throughout the state noting babies screened and why, and re-screens.
2. Provide technical support to hospitals with regards to the screening process and use of equipment.
3. Implement appropriate measures when hearing impairments are apparent.
4. Purchase and distribute 60percent of supplies necessary to carry out universal screening.

Monitoring:

1. Monthly reviews of county specific newborn screening reports.
2. Monthly review of referral logs.
3. Review entire screening log from all hospitals.

Evaluation:

1. The percent of births screened.
2. Number of positive cases identified.
3. Proportion of infants with inherited disorders identified through the screening process who received follow up care.
4. The percent of infants who received intervention within two months of diagnosis.

(Priorities #5 & #9)

NPM #4: Percent of newborns in the State with at least one screening for each of PKU, Hypothyroidism, Galactosemia, Hemoglobinopathies.

Maintain 99.8percent of all newborns screened for genetic disorders.

Activities:

1. Continue to provide screening of all births occurring in the state and follow-up on all positives for diagnosis and treatment.
2. Identify positive cases detected in screening process.
3. Schedule follow-up visit for positive cases.
4. Continue to provide evaluations and counseling for families of

infants who test positive during newborn screening.

5. Continue to assist in coordinating the care of affected infants with local health departments and private physicians where applicable.
6. Develop software enhancements to detect all positive cases who have not received follow-up.

Monitoring:

1. Monthly review of county newborn screening reports.

Evaluation:

1. Number of positive cases that remain in a system of care for at least 12 months.

Preventive/Primary Care Services for Children/Adolescents

(Priorities #4 & #9)

NPM #5; Percent of children through age 2 who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, hepatitis B.

Increase the percent of children through 27 months who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

Activities:

1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rates of two year old children in Mississippi.
2. Continue to emphasize, through the Statewide Immunization Coalition, the significance of immunizations before two years of age.
3. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP) to ensure that providers receive new immunization schedules developed jointly by the MSDH and AAP to create a unified immunization schedule for the state.

Monitoring:

1. Review annual immunization surveys.
2. Quarterly review of coalition immunization activities occurring in

local communities.

Evaluation:

1. The number of children through age two who receive required immunizations.

(Priorities #7, #8 & #10)

SPM #2: Current Percent of Cigarette Smoking Among Ninth Through Twelfth.

1. Reduce cigarette smoking among ninth through twelfth graders.

Activities:

1. Through EPSDT, Family Planning and other adolescent counseling visits, directly counsel youths concerning hazards of cigarette smoking.
2. Maintain community-based tobacco prevention programs in collaboration with the Partnership for a Healthy Mississippi.
3. Maintain use of tobacco prevention curricula in school.
4. Conduct site visits to at least 15 schools.
5. Staff training on smoking cessation specifically targeted to adolescents.
6. Make literature available to counties on smoking cessation.

Monitoring:

1. Prepare school nurse reports based on year 1 activities.
2. Review YRBS data.
3. During chart audits, determine if adolescent is/was a smoker and if smoking cessation counseling was provided or if client has been referred for smoking cessation classes.

Evaluation:

1. Decrease/increase in percent of students in the ninth through twelfth grades using cigarettes.

(Priorities #1, #5, & #8)

NPM #6 : The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Reduce the birth rate for teenagers age 15 through 17 years of age.

Activities:

1. Support MSDH's Statewide Abstinence Education Program.
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy and other issues concerning Mississippi's youth.
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minority health problems.
4. Collaborate with community health centers in all medically underserved counties regarding the provision of free contraceptives to teens, and continue to support current contracts with annual site visits and technical support.
5. During postpartum home visits, counsel teens regarding availability of family planning services.
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting.

Monitoring:

1. Review vital statistics data related to teen pregnancy and births to teens.
2. Review Youth Risk Behavior Survey (YRBS) data.

Evaluation:

1. Decrease in teen pregnancy and birth rates.
2. Decrease in the number of teens reporting initiating or continuing early sexual activity.
3. Increase in sexually active youth reporting on the YRBS the use of condoms or other contraceptives.

(Priorities #1, #5, & #8)

SPM #7: The Rate of Repeat Birth (per 1,000) for Adolescents Less than 18 Years Old.

1. Reduce the rate of repeat births for adolescents less than 18 years old.

Activities:

1. Continue to sponsor, through MSDH's Family Planning Program, collaborative training such as conferences and male involvement workshops.
2. Continue to support the training of MCH/Family Planning

(MCH/FP) Coordinators to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-conceptional spacing.

3. Continue to work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients.
4. Encourage health departments to provide enhanced family planning services to adolescents, including PHRM/ISS case management.
5. Increase follow-up of teen clients and flexible clinic schedules to help increase access for teens.
6. Partner with the Mississippi Chapter of the March of Dimes to implement at least one Project Alpha Program in the state to increase healthy lifestyle behaviors among adolescent males through education and responsible decision making.
7. Work with the Division of Medicaid in support of the Family Planning waiver.

Monitoring:

1. Random chart audits of teen clients, reviewing pregnancy history and access to case management services.
2. Teen participation in family planning clinics.

Evaluation:

1. Increase or decrease in the number and rate of repeat teen pregnancies and births compared to previous year.

(Priorities #5, #7, #8, & 10)

SPM #3: Smoking Among Pregnant Adolescents.

2. Decrease cigarette smoking among pregnant adolescents.

Activities:

1. Provide data by county to health department staff to target areas of greatest need.
2. Work with school nurses and health educators to increase the number of school-based health education programs related to smoking.
3. Continue to educate adolescent pregnant women receiving health department services on the dangers of smoking and the affects on the fetus.
4. Provide specific educational training related to smoking and

pregnancy to nurses, nutritionists and health educators.

Monitoring:

1. Review birth certificates annually for decrease/increase in the number of adolescents reporting smoking.

2. During record audits, determine if clients were assessed for smoking and if counseling or referral was provided.

Evaluation:

1. Decrease in the number of pregnant smoking teens.

2. Decrease in low birthweight births among teens.

(Priorities #2 & #9)

NPM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Increase the number of third grade children with access to dental health services, including the placement of protective sealants on at least one permanent molar tooth.

Activities:

1. Disseminate information through local health departments to parents to increase awareness of protective sealants.

2. Encourage increased utilization of dental services provided by Medicaid through:
    - increased parental awareness
    - outreach to dentists to encourage participation
    - working with Medicaid to address reimbursement issues
3. Contract with Dr. Stephen L. Silberman and the University of Mississippi School of Dentistry to screen third grade public school students in each of Mississippi's nine public health districts.

Monitoring:

1. Monthly review of utilization rates.

Evaluation:

1. The number of third grade children who receive protective dental sealants.
2. The number of sealants provided through Medicaid dental services.
3. The percentage of children receiving sealants as part of EPSDT services.

(Priorities #2 & 8)

NPM #8: The rate of deaths to children age 1-14 caused by motor vehicle crashes per 100,000 children.

Collaborate with agencies and community-based organizations to develop initiatives to decrease death to children age 1-14 caused by motor vehicle crashes.

Activities:

1. Collaborate with the Safe Kids of Mississippi Coalition to initiate the passage of legislation regarding child passenger safety.
2. Partner with local health departments to provide child safety seats to all residents of the state who need and can not afford safety seats.
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats.
4. Place educational videos and informational TIPP sheets developed by the Ford Motor Company in each health district for staff training purposes and dissemination to clients.
5. Maintain MSDH's participation with the Mississippi Association of Highway Safety Coalition to prevent death in children age 1-14 due to motor vehicle crashes.

Monitoring:

1. Quarterly review of child safety seat distribution.
2. Quarterly review of staff and parent training seminars conducted.
3. Annual review of vital statistics data.

Evaluation:

1. The number of car seats provided to needy residents in the state.
2. The number of training seminars conducted.
3. Passage of legislation regarding child safety seats.

<u>Infrastructure Building Services</u>

Pregnant Women, Mothers and Infants

(Priorities #2, #5 & #6)

NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester.

Activities:

4. Collaborate with the Division of Medicaid and the Department of Human Services to include in AFDC checks and Food Stamp mailouts, information on prenatal care, WIC, and family planning.
2. Collaborate with HealthMAC providers to provide PHRM/ISS case management.
3. Collaborate with the Mississippi Food Network to distribute information on the importance of early prenatal care.
4. Collaborate with the March of Dimes to develop media materials related to the importance of early and prenatal care.

Monitoring:

1. Number of Mississippi Food Network sites requesting and distributing materials.
2. Number of county Food Stamp offices and county offices of the Department of Human Services contacted and number of mailouts with pamphlets related to prenatal care and family planning.

Evaluation:

1. In areas where outreach efforts are initiated, determine the effectiveness by comparing the number of calls and mailouts by county with the percentage of women, by county, entering prenatal care according to month of entry.
2. Increase in the percent of women seeking early prenatal care.

(Priority #5)

NPM #15: Percent of very low birthweight live births.

Reduce the percent of very low birthweight births.

Activities:

1. Distribute pamphlets to health care providers to inform their patients about the availability of WIC.

2. Coordinate WIC promotion activities with LBW prevention strategies.
3. Work closely with WIC to provide new and continued outreach efforts to potentially eligible populations.
4. Continue to work with MSDH districts to explore the possibility of off-site (out of clinic) WIC certification sites such as distribution centers, and Head Start centers.
5. Assess pregnant women for smoking and offer smoking cessation classes (where available), materials, and counseling.
6. Increase participation in PHRM/ISS.

Monitoring:

1. Number of off-site certification sites.
2. Number of health care providers contacted.

Evaluation:

1. Increase in WIC participation according to areas of the state targeted for intervention.
2. Decrease or increase in percent of very low birthweight births.
3. Increase in PHRM/ISS participation statewide.

(Priorities #2, #5 & #6)

NPM #17: The percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates.

Increase the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates.

Activities:

1. Work with the Mississippi Perinatal Association, the Infant Mortality Task Force, and the March of Dimes to evaluate the regionalization system in the state.
2. Evaluate the current system and develop a plan of improvement if needed.
3. Develop risk assessment tools and referral criteria.
4. Disseminate risk assessment tools to providers and provide training on its use and on referral criteria.
5. Support training activities to local hospitals and providers on risk assessment and stabilization of women and newborns at risk.
6. Develop tracking system to monitor early identification, referral, and follow-up of women and newborns at risk.

Monitoring:

1. Number of maternal and newborn transports.
2. Sign-in sheets from training sessions and evaluation at completion of training sessions.

Evaluation:

1. Increase in the percent of very low birthweight infants born in tertiary hospitals.

Preventive/Primary Care Services for Children/Adolescent

(Priorities #4 & #9)
NPM #12: Percent of children without health insurance.

Collaborate with the Department of Finance and Administration (DFA) and Medicaid to develop a system for determining the percent of Mississippi's children without health insurance and to improve the public's awareness of CHIP.

Activities:

1. Meet with DFA and Medicaid representatives to discuss alternatives for determining the percent of children in Mississippi without health insurance.
2. Assist DFA and Medicaid in marketing the availability of CHIP to eligible families and/or clients.

Monitoring:

1. Quarterly review of Medicaid and CHIP enrollment reports.

Evaluation:

1. A decrease in the current percentage of children without health insurance.
2. Increase in the number of families/clients enrolled in the CHIP and Medicaid programs.

(Priorities #4 & #9)
NPM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Collaborate with Medicaid to develop a system for data sharing to determine the number of

potentially Medicaid eligible children and to track the number of eligible children receiving a service through the Medicaid program.

Activities:

1. Develop a Memorandum of Understanding with Medicaid regarding the exchange of data.
2. Encourage use of out-stationed eligibility workers to assist Medicaid eligible clients in completing the Medicaid/CHIP eligibility form.
3. Local health department staff will assist potentially eligible clients to apply to Medicaid and CHIP.

Monitoring:

1. Quarterly review of Medicaid and CHIP enrollment and service reports.

Evaluation:

1. The number of potentially Medicaid eligible children receiving a service paid by Medicaid compared to the previous reporting period.
2. An increase in the number of children enrolled in the Medicaid/CHIP program.

(Priority #8)

NPM #16: The rate (per 100,000) of suicide death among youths 15-19.

Reduce the rate of suicide deaths among youths 15-19.

Activities:

1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the communication gaps between adolescents and their families.
2. Collaborate with the Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention.
3. Review records to screen for high risk youth.

Monitoring:

1. Review annually the results of the YRBS.
2. Annual review of EPSDT, Family Planning and other MCH records.
3. Annual review of vital statistics data.

Evaluation:

1. Statistically significant changes in the suicide rate in the adolescent population.
2. A reduction in the number of reported suicide deaths among youths age 15-19.

Services for CSHCN

(Priorities #2 & #9)

NPM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.

Identify the percent of CSHCN in the State's CSHCN Program who have a source of insurance for primary and specialty care.

Activities:

1. Include insurance information on CMP applications
2. Verify insurance status at all patient encounters and make referrals to Medicaid, CHIP or other sources as needed.
3. Develop and implement a reliable data system for the CMP Program.

Monitoring:

1. Review of current billing activity for the primary CSHCN clinic.
2. Review a sample of charts at Blake Clinic to determine the number of clients queried about insurance status.

Evaluation:

1. The percent of CSHCN in the state who have a source of insurance for primary and specialty care.

(Priority #9)

NPM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Assure family participation in program policy activities in the State's CSHCN Program.

Activities:

1. Increase family participation on the program advisory committee.
2. Expand patient and parent subcommittee of the advisory committee.
3. Include patient and family subcommittee's input in the MCH Block Grant Needs Assessment.
4. Continue parent involvement in the Transition Task Force.

Monitoring:

1. Review patient/parent satisfaction surveys regarding CSHCN service delivery.

Evaluation:

1. Comparison with previous year performance measure rating.

4.2 Other Program Activities

The Children's Medical Program (CMP) currently serves approximately 6,249 children annually. Eligibility is based on diagnostic criteria and family income. Diagnoses include certain orthopedic, gastrointestinal, genetic disorders and other related handicapping conditions.

The MSDH Children's Medical Program (CMP) has in place a cross referral system with the State Disability Determination Service (DDS) Agency. Every person applying for SSI who meets the disease eligibility requirement for SSI is referred for evaluation enrollment. Also, every person applying for CMP who appears to meet SSI eligibility criteria is referred to DDS. This arrangement reinforces the network of services established by CMP throughout the state to ensure that children have access to all available community based service delivery resources. The MSDH's Children's Medical Program (CMP) maintains an open dialogue with the Disability Determination Agency which allows them to submit to this agency all SSI applications of children less than 16 years of age for review, who might be eligible to receive CMP services. The CMP and DDS have completed an MOU covering assurance of rehabilitative services to children <16 years of age who receive SSI benefits (see copy of MOU in the appendices).

The CMP plans to continue to utilize the CMP Advisory Council to communicate with and receive feedback from health care providers and consumers. The Advisory Council includes specialty and sub-specialty physicians, (pediatricians, pediatric orthopaedic surgeons, pediatric cardiologists, etc), dentists, physical therapists and other health care

providers, and parents of CMP patients. Through this effort, providers will continue to be advised of program efforts such as the expanded effort to provide services to disabled children under sixteen years of age who receive SSI benefits under Title XVI, and the coordinated efforts to assist CMP patients in having a medical home.

The CMP will also continue to develop and strengthen lines of communication with all state agencies who provide assistance to CSHCN and their families. In addition to the established efforts previously mentioned with Medicaid, SSI/DDS, and the CMP Advisory Council, the Ad Hoc Committee on Child SSI Beneficiaries meets quarterly to address both policy and care issues. Members of this group include representatives from the state offices of CMP, SSI, DDS, Medicaid, Mental Health, and Department of Education, as well as Senator Lott's and Congressman Thompson's offices, and Family Voices, a statewide advocacy organization.

The MSDH MCH programs maintain four toll-free service lines: Take Care Service Line, CMP, Genetics, and FSEIP. These lines provides assistance to clients seeking MCH services, Medicaid, WIC, and other services and/or information. This is a valuable tool for encouraging early entry into prenatal care and to further link the private and public sectors. The MSDH will continue to monitor the utilization of the service lines and seek strategies for its improvement. Publicity of this service will continue to be done through Medicaid eligibility fliers printed by the MSDH and the Division of Medicaid, and through newsletters published by the Mississippi Chapter of the American Academy of Pediatrics and patient educational materials.

Historically, the MSDH has been a major provider of EPSDT services and has assisted the State’s Title XIX agency in developing service components and standards. This relationship was expanded through a joint effort between the two agencies in securing legislation authorizing the Division of Medicaid to develop and implement, in conjunction with the MSDH, a program of case management and enhanced psychosocial and nutrition counseling, and health education for high risk pregnant women, mothers and infants who are Medicaid eligible (Perinatal High Risk Management/Infant Services System).

PHRM/ISS funds are made available by using part of the state fund appropriation of the MSDH as match for HCFA funding. Along with the expanded eligibility under OBRA 89 to 185percent of federal poverty level for women and infants, this initiative provides another critical component for the development of a system responsive to the prevention and primary care needs of low-income pregnant women, mothers and infants.

In 1997, the Mississippi Infant Mortality Task Force was instrumental in assisting the MSDH to secure a SPRANS grant from the Maternal and Child Health bureau to conduct a three year Fetal and Infant Mortality Review (FIMR) study. FIMR is a community-owned, action-oriented process that results in improved service systems and resources for

women, infants and families. The FIMR process brings together a community team to examine confidential, de-identified cases of infant deaths. The purpose of these review is to understand how a wide array of local, social, economic, public health, educational, environmental, and safety issues relate to the tragedy of the loss.

The administration, collection, and processing of MSDH provider data is performed as a function of the on-going electronic billing process through the Office of Third Party Payments. As a provider of Title XIX and Title V services, the MSDH regularly bills Medicaid for services to patients covered by Title XIX and pays for services provided to Title V eligible patients who are not eligible for Title XIX services from MCH Block Grant funds.

During FY 2001 the MSDH will continue its joint efforts with Medicaid to assess pregnant women and children for Medicaid and CHIP eligibility using a two-page eligibility form with 200 percent of poverty as a threshold. This form was developed through an interagency effort by the Division of Medicaid, the Department of Human Services, the State Department of Health, and the Mississippi Primary Health Care Association. Its special features includes the mail-in opportunity and simplification of verifications which may be photocopied. Eligibility workers are located in several health departments and community health centers in public health districts where funding is available to provide 50percent matching funds. These workers accept applications, thereby preventing untimely delays for clients who need Medicaid coverage.

4.3 Public Input

In addition to input from the MSDH MCH Block Grant Workgroup, described earlier, the MSDH solicited public input by hosting four (4) public hearings in strategic areas of the state. Health officers in each of the nine public health districts were encouraged to conduct a public hearing for their particular district. In conducting public hearings, health officers were responsible for inviting local citizens and key community leaders to inform them and solicit their support and concerns regarding the preparation and implementation of the MCH Block Grant in our state. Public hearings were held in Jackson, Meridian,

Tupelo, and Gulfport, Mississippi during the month of June. The hearings were advertised through key public newspapers in the state.

Copies of the grant are also made available in all nine public health district offices for public review and/or comment, with a copy also maintained in the Office of the State Health Officer. Public input was invited through key parent and family support groups that are affiliated with programs funded by the grant and meet throughout the year.

4.4 Technical Assistance

(Technical Assistance Is Being Requested, See Form 15).

V. Supporting Documents

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For***

planning and systems development) Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment,

common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination,

translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be

achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are

essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or postpartum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local*

funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18 Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
    (1) The dangers of drug abuse in the workplace;
    (2) The grantee's policy of maintaining a drug-free workplace,
    (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
    (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
    (1) Abide by the terms of the statement; and
    (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a

central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measurement Detail Sheets